KELSEY TRAIL
HEALTH REGION

Annual Report to the Minister of Health

For the 2012-13 Fiscal Year Ended March 31, 2013

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The Kelsey Trail Health Region Annual Report for the fiscal year ending March 31, 2013 is available on the internet at www.kelseytrailhealth.ca.

Kelsey Trail Health Region is the operating name for the Kelsey Trail Regional Health Authority. Most references to this organization use Health Region, except in reference to the governing board, which is referred to as the Regional Health Authority. Health Region also refers to the geographic areas served by the Kelsey Trail Health Region.

Letter of Transmittal

June 26, 2013

Honourable Dustin Duncan
Minister of Health

Dear Minister Duncan:

The Kelsey Trail Regional Health Authority is pleased to provide you and the residents of the health region with its 2012-13 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the region for the year ended March 31, 2013.

The Kelsey Trail Regional Health Authority is pleased to report several accomplishments during the 2012-13 fiscal year including:

- all six acute care sites joining the Saskatchewan Lab Results Repository;
- receiving approval for a shift in scope for the Kelvington long term care replacement project to an integrated facility and utilizing lean continuous improvement methodology in the design approach through 3P (Production Preparation Process); and
- expanding primary health care services in the region to include the community of Kelvington.

The overall success of the health region can be attributed to the compassion, dedication and commitment of the Kelsey Trail Health Region's greatest resource – its physicians and employees.

Respectfully submitted,

Rennie Harper

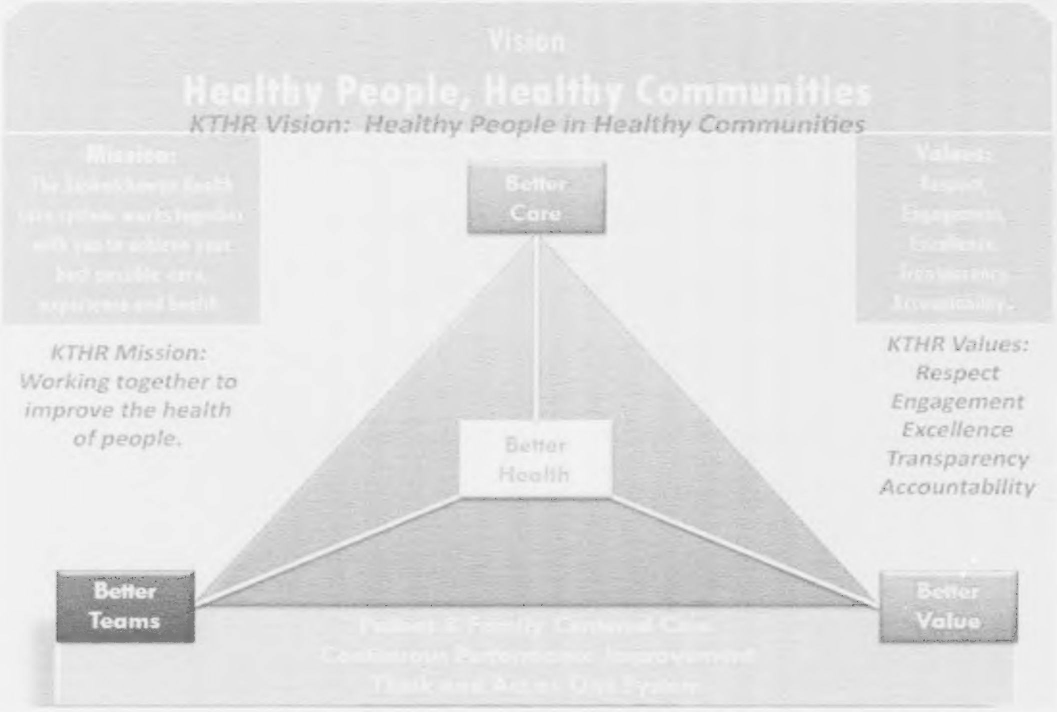
Rennie Harper
Chairperson
Kelsey Trail Regional Health Authority

Introduction

The 2012-13 annual report presents the activities and the results of strategies, actions and performance measures identified within the 2012-13 Health System Plan for the fiscal year ended March 31, 2013. This report demonstrates Kelsey Trail Health Region's progress toward meeting 2012-13 targets and commitments, providing an opportunity to assess accomplishments, results and lessons learned while identifying how to improve on previous successes for the benefit of the residents of the health region.

Under Section 55 of *The Regional Health Services Act*, the Kelsey Trail Regional Health Authority (KTRHA) is legislatively required to report on its annual activities. The Authority is collectively responsible for leading the organization in determining, monitoring and assuring appropriate organizational performance. The annual report provides accountability for the activities of the KTRHA to residents and the Ministry of Health.

The information in the annual report is driven by standards, best practise, performance measures and indicators, outcome benchmarks, statistical and environmental data collected by a variety of credible provincial and national organizations and bodies by which the overall performance of health care services and programs are measured.


Vision
Healthy People, Healthy Communities
KTHR Vision: Healthy People in Healthy Communities
Mission:
The Saskatchewan health care system works together with you to achieve your best possible care, experience and health.
Values:
Respect, Engagement, Excellence, Transparency, Accountability.
Better Care
KTHR Mission: Working together to improve the health of people.
KTHR Values: Respect Engagement Excellence Transparency Accountability
Better Health
Better Teams
Better Value
Patient & Family Centred Care
Continuous Performance Improvement
Think and Act as One System

Alignment with Strategic Direction

The health region's Vision, Mission and Values reflect the overall direction of the health system. The regional values are aligned with the provincial values of Respect, Transparency, Excellence, Accountability and Engagement.

The 2012-13 Health System Plan represents a new approach to strategic planning, known as Hoshin Kanri. This method of strategic planning features a collaborative approach to determining strategic priorities and how to achieve them through the engagement of all levels of staff in a process referred to as "catchball".

Provincial priorities are focused on the 100 Year Strategies: Better Health, Better, Care Better Teams and Better Value. These enduring strategies are based on the Institute for Healthcare Improvement's (IHI) Triple Aim.

Provincially, five areas for breakthrough initiatives were identified for improvement over a 12 to 18 month period. These include:

- transform the surgical patient experience;
- strengthen patient-centred primary health care;
- deploy a provincial continuous improvement system;
- focus on patient and staff safety; and
- identify and provide services collectively through a shared services organization.

The successful implementation of these five breakthrough initiatives is expected to influence achievement of the three to five year outcomes. Regional priorities are aligned with the strategic goals and improvement targets established in the 2012-13 Health System Plan. The provincial breakthrough initiatives guide the strategic priorities of the health region.

The 2012-13 Accountability Document issued annually by the Ministry of Health clarifies the priorities, expectations and the reporting requirements of the Regional Health Authority. It is also intended to complement existing legislation, regulations, contracts, ministerial directives and policies, establishing expectations based on achieving the targets set in the 2012-13 Health System Plan. Regional strategic planning is influenced and impacted by financial, operational, capital and human resources. Recruitment and retention have the most significant impact on the region's ability to achieve provincial targets.

The Patient First Review Commissioner's Report to the Saskatchewan Minister of Health, a focus on Lean and continuous quality improvement initiatives, and a commitment to thinking and acting like one for the benefit of patients and families are the foundations upon which all provincial and regional health system planning are based. Supporting provincial documents such as the Patient & Family Centred Care (PFCC) Framework, the Saskatchewan Surgical Initiative (SKSI) Plan, the Primary Health Care Framework, the HIV Strategy, as well as the standards set by Accreditation Canada, the Canadian Standards Association (CSA) and *SaferHealthcareNow!* (SHN) also shape strategic priorities.

Better Health

Improve population health through health promotion, protection and disease prevention, and collaborate with communities and different government organizations to close the health disparity gap.

Provincial 3-5 Year Outcomes	**Provincial Hoshins (12-18 month Breakthroughs) 2012-13**	**KTHR Hoshins (12 – 18 month Breakthroughs) 2012-13**
50% reduction in the incidence of communicable disease (TB, HIV, STIs & MRSA) by 2017	Strengthen patient-centred Primary Health Care by improving connectivity, access and chronic disease management.	Primary Health Care Electronic Medical Record (EMR)
50% improvement in number of people surveyed who say "I can see my primary health care team on my day of choice" by 2017		Chronic disease management – with initial focus on screening for renal insufficiency at Cumberland House
50% reduction in age-standardized hospitalization rate for ambulatory sensitive conditions by 2017		Suicide Risk Assessment Tool – focus due to high suicide rate in KTHR
100% of seniors who choose to stay at home will be supported to do so as long as it is safe and economically efficient to do so by 2017		

Better Care

In partnership with patients and families, improve the individual's experience, achieve timely access and continuously improve health care safety.

Provincial 3-5 Year Outcomes	Provincial Hoshins (12 – 18 month Breakthroughs) 2012-13	KTHR Hoshins (12-18 month Breakthroughs) 2012-13
By March 31, 2017, patients' ratings of exceptional overall health care experience are in the top 20% of scores internationally	Transform the patient experience through Sooner, Safer, Smarter Surgical Care	Surgical safety checklist – the team uses a surgical safety checklist to confirm safety steps are completed for a surgical procedure.
By March 2017 there will be a 50% reduction in patient wait times from GP referrals to specialist and diagnostic services		
By March 2014 all persons have the option to receive necessary surgery within 3 months		
By March 2015 all cancer surgeries or treatment are done within the consensus time frames from the time of suspicion of, or diagnosis or, cancer		
By March 2017 no adverse events related to medication errors	Safety Culture: focus on patient and staff safety	KTHR reconciles clients' medications at admission and transfer or discharge from acute, long term care and home care services
By March 2017 zero surgical infections in clean surgeries		
Individuals with severe and complex mental health issues with alcohol co-morbidity or acquired brain injury will have access to supportive housing in or near their community in 2017		
No patient that requires emergency services will wait in the ER for care by March 2017		

Better Teams

Build safe, supportive and quality workplaces that support patient and family-centred care and collaborative practices, and develop a highly skilled, professional and diverse workforce that has a sufficient number and mix of service providers.

Provincial 3-5 Year Outcomes	Provincial Hoshins (12 – 18 month Breakthroughs) 2012-13	KTHR Hoshins (12 – 18 month Breakthroughs) 2012-13
Increase physician engagement "score" by 50% by March 2017	Deploy a continuous improvement system including training, infrastructure across the health system with an initial focus on the surgical value stream and capital projects using 3P (Production Preparation Process)	Build Lean capacity to promote and manage all improvement activities with a focus on our clients
By March 31, 2017, the employee engagement provincial average score exceeds 80%		Capital Projects: Kelvington Integrated Facility capital project will provide an opportunity to learn about the Lean 3P
By March 31, 2017, zero workplace injuries	Safety culture: focus on patient and staff safety	Safety culture: employee plan for safety management system which will identify hazards and control risks to reduce workplace injuries

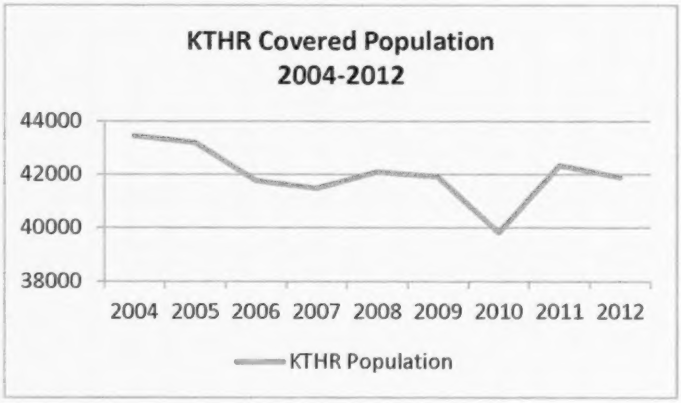
Better Value

Achieve best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure.

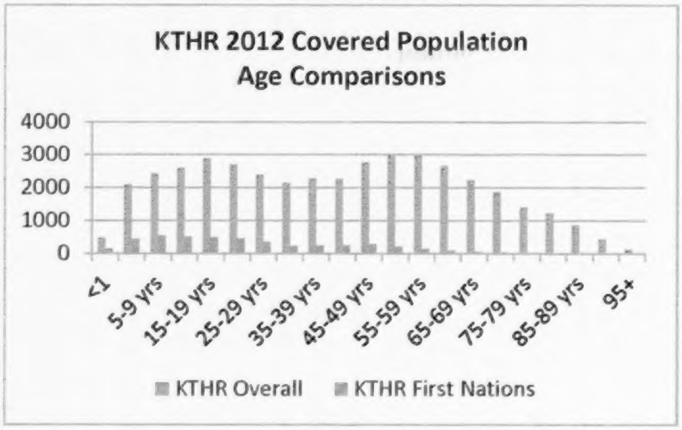
Provincial 3-5 Year Outcomes	Provincial Hoshins (12-18 month Breakthroughs) 2012-13	KTHR Hoshins (12-18 month Breakthroughs) 2012-13
By March 2017 (based on a 5 year rolling average), the health care budget increase is less than the increase to provincial revenue growth	Identify and provide services collectively through a shared services organization	Shared Services: Participate in GHX - health care supply chain provincially to reduce health care spending
By March 31, 2017, 8% of the health care budget is strategically invested in IT, equipment and facility renewal		Shared Services: Workflow management self-service – reduce the amount of time spent processing employee-related data

Overview

The RHA is responsible for providing safe, quality, timely, effective and efficient primary and secondary health care services to the population of the region. Services are available and accessible to residents as reasonably close to home as possible. The large geographic area of the region (44,369.62 square kilometres) and the relatively sparse population pose challenges in achieving this goal.



Source: *Ministry of Health. 2012 Covered Population.*



Source: *Ministry of Health. 2012 Covered Population.*

According to 2012 Covered Population statistics, the total population of the region is 41,889, one percent less than the previous year. The First Nations population (4,520) represents 10.79% of the region's total population. At 1.85 persons per square kilometre, the provincial population density is almost twice that of KTHR (0.94 persons per square kilometre). The Covered Population represents an annual count of people who have Saskatchewan Health coverage. Only residents registered for provincial health coverage are included in the Covered Population, which may not include everyone who is a resident of the province as of June 30th.

Health services are provided to the residents of 58 rural and urban municipalities, five First Nation communities and the Northern Village of Cumberland House. In some cases, services to First Nation communities are delivered by KTHR in partnership with other agencies. Services not available within the region are accessible and available to residents through visiting services, referrals and the Telehealth Saskatchewan network.

Approximately 32 physicians and 1,600 staff provide a broad range of community and facility-based services and programs. Physician resources include a Chief of Staff/Vice-President of

Medical Services, a Medical Health Officer, a resident General Surgeon, a visiting Radiologist, General Practitioner/Anaesthetists, and General Practitioner/Obstetricians.

The region ensures a wide range of accessible itinerant services by granting visiting privileges to a number of physician specialists at district hospitals in Melfort, Nipawin and Tisdale. Services include nephrology, physical medicine and rehabilitation, psychiatry, podiatry, rheumatology, paediatrics, obstetrics and gynaecology, ear/nose/throat, orthopaedics and orthopaedic surgery, ophthalmology, respiratory medicine, internal medicine, urology, plastic surgery and general surgery. Associate privileges are also granted to dental and chiropractic service providers.

In total, 116 acute care beds (observation, respite, palliative, convalescent and rehabilitation) are staffed and operational within district hospitals in Melfort, Nipawin and Tisdale and community hospitals in Hudson Bay, Kelvington and Porcupine Plain. Health centres are located in Arborfield, Carrot River, Cumberland House, Rose Valley and Smeaton. Lab and x-ray services are available in the district and community hospitals. Laboratory services are also available at all four health centres while x-ray services are only available at Carrot River. Radiology services have been discontinued at the other health centres over the past few years due to low volumes, the availability of digital imaging and the provincial Picture Archiving & Communication System (PACS) at neighbouring hospitals.

In total, 482 long term care and respite beds are staffed and operational in Arborfield, Carrot River, Hudson Bay, Kelvington, Melfort, Nipawin, Porcupine Plain, St. Brieux and Tisdale. Four Dementia units operate within long term care facilities in the region.

Pre-hospital emergency care is available through a combination of RHA-owned and contracted emergency medical services. Trained volunteer First Responders and Ancillary First Responder groups provide emergency services to a large number of communities and areas in Kelsey Trail. The region provides training to volunteers in community groups, organizations, schools and corporations who have invested in Public Access Defibrillators (PADs).

Primary Health Care (PHC) sites are located in Arborfield/Carrot River, Cumberland House, Hudson Bay, Kelvington, Naicam, Nipawin, Porcupine Plain and Tisdale. PHC services are delivered by Physicians and NPs working collaboratively in teams with other health care professionals including Nutritionists, Speech/Language Pathology, Early Childhood Psychology, Dental Health, Dietitians and Nurse Educators, Chronic Disease Management, Community Wellness Coordinators, and Therapies which includes an Autism Spectrum Disorder consultant, the Acquired Brain Injury program, Exercise Therapists, Recreation Therapists, Physical and Occupational Therapists. In total, 80.53% of the population of KTHR has access to PHC services.

Employees of Community and Primary Health Care (PHC) deliver services to more than 30 different locations in the region, focusing on community development and population health promotion, and include the services of Home Care, Public Health, Environmental Health, Therapies and Mental Health & Addiction. The Public Health unit includes public health nursing, travel health, the regional Medical Health Officer and Communicable Disease/Immunization Coordinator. Public health inspection, tobacco enforcement and water monitoring services are delivered regionally by the Environmental Health unit.

The region has a well-established Saskatchewan Telehealth video conferencing program which provides a link for rural and urban health care professionals to schedule specialist appointments, consults, clinical visits and follow-up appointments for patients and clients. It is also used for educational sessions for health care professionals and members of the public.

Community Wellness Coordinators in Hudson Bay, Kelvington, Nipawin and Tisdale provide services to school-aged populations in Arborfield, Archerwill, Porcupine Plain, Rose Valley, Star City and Zenon Park.

Mental Health & Addiction Services (MHAS) are provided regionally through a combination of community-based locations and visiting services. Inpatient services and 24-hour emergency mental health referrals and consultations are available through a partnership with the Prince Albert Parkland Health Region (PAPHR). Medical Social Worker services are also available through MHAS.

Volunteer services are coordinated through the Human Resources (HR) department and include the parent mentoring program, pastoral care, youth programs, gift shops, meals on wheels, auxiliaries, drivers and activity volunteers. Volunteers provide countless hours of service to the region every fiscal year.

Community Based Organizations

The region acts as the accountable partner in contractual relationships with a number of independent Community Based Organizations (CBOs) and third parties for the delivery of health care services. CBOs are prescribed organizations that receive funding from KTHR to provide health services. The region is responsible for financial monitoring, ensuring adequate resources are being provided, and accountability among CBOs.

KTHR has contractual relationships with the following CBOs:

- Kelvington Ambulance Care Ltd., Tisdale Ambulance Care Ltd., Shamrock Ambulance Care Inc. (Rose Valley Division), North East EMS (Nipawin & Carrot River) and Melfort

Ambulance Service Care (1999) Ltd. – emergency medical/ambulance services operating in the boundaries of the health region; and

- Nipawin Oasis Community Centre Cooperative - services for clients with long term mental illness in the Nipawin area.

Partnerships

Kelsey Trail has developed a number of mutually beneficial partnerships that provide strong connections to community, enhance resource-sharing opportunities and have long term impact on meeting the needs of the population.

Ministry of Health

The region's most significant stakeholder, the Ministry provides strategic and policy direction, sets and monitors standards, provides funding, and supports the health region to ensure the provision of essential and appropriate services to residents.

Health Shared Services Saskatchewan (3sHealth)

3SHealth provides select administrative and support services through a shared services model, including payroll and group benefits administration and contract administration for group purchasing.

Saskatchewan Association of Healthcare Organizations (SAHO)

SAHO provides labour relations services, including collective bargaining, as the representative employers' organization.

Prince Albert Parkland Health Region (PAPHR)/Sunrise Health Region (SHR)

KTHR has an historical partnership with PAPHR for the provision of Mental Health & Addiction Services, primarily in specialty mental health services such as psychiatry, eating disorders and psychologist supervision. The region also partners with PAPHR on the F.A.S.T. Stroke Bypass Protocol as well as the delivery of orthopaedic surgical services at Nipawin Hospital.

Athabasca Health Authority (AHA)

A partnership with AHA has resulted in the provision of Information Technology support to the northern health region. Through the partnership, AHA has also benefitted from the development and launch of the regional Radiography Information System-Picture Archiving Communication System (RIS-PACS) for the secure storage and retrieval of diagnostic images in digital format.

Saskatoon Health Region

A partnership with Saskatoon Health Region has resulted in the provision of Privacy support and services to KTHR by the Saskatoon Health Region's Privacy & Access Office.

Sunrise Health Region

The region partners with Sunrise Health Region on the F.A.S.T. Stroke Bypass Protocol.

North East Regional Intersectoral Committee (NERIC)

The health region is an active partner on the NERIC which includes representation from the North East School Division, Cumberland College, the Ministry of Social Services, Métis Nation Eastern Region 1 & 2, and several other human resource agencies. Through this partnership, the region facilitates and supports community-based approaches and initiatives in response to the needs of children, youth and families.

KidsFirst

KTHR is the accountable partner for the *KidsFirst* targeted and non-targeted programs in the region. *KidsFirst* is a voluntary program that works in collaboration with existing community programs to help vulnerable families, enhancing knowledge, providing support and building on family strengths.

Saskatchewan Cancer Agency

In partnership with the SCA, KTHR operates the Screening Program for Colorectal Cancer. The program targets men and women between 50 and 74 years of age who are at risk of developing colorectal cancer.

Cumberland College/Saskatchewan Institute of Applied Science & Technology (SIAST)/ University of Saskatchewan

KTHR partners with all three educational institutions to provide practicum opportunities for post-secondary students to meet their educational needs.

Union Affiliates

The region has developed respectful partnerships with union affiliations. In addition to the Saskatchewan Union of Nurses (SUN), KTHR works in partnership with the Health Sciences Association of Saskatchewan (HSAS) and the Saskatchewan Government & General Employees Union (SGEU).

Municipal Stakeholders

The health region regularly partners with municipal bodies to address program and service needs. The health region is working in partnership with the Town of Kelvington, Town of Tisdale and surrounding municipalities on long term care replacement projects. In Tisdale, the health region is also involved in a partnership with the Town in the development of a community health complex.

Other significant partnerships include community Foundation and Trust committees and auxiliaries, the Health Quality Council (HQC), the Northern Health Strategy, the Northern

Chronic Care Coalition, the Northern Antibiotic Resistance Partnership (NARP), Prince Albert Grand Council, Saskatoon Tribal Council, Métis Nation Eastern Region 1 & 2, the Northern Inter-Tribal Health Authority (NITHA), the Aboriginal Employment Development Program (AEDP), Lakeland District Sport Culture & Recreation and North Sask Laundry & Support Services.

Administrative Structure

The Chief Executive Officer (CEO) works with an Executive Management Team that includes the Vice-President Institutional & Emergency Care, the Vice-President Corporate Services, the Vice-President Community & Primary Health Care and the Vice-President Medical Services/Chief of Staff. The Executive Assistant to the CEO and Corporate Communications Officer serve as resources to the Executive Management Team.

Following the resignation of the Vice-President Community & Primary Health Care in May 2012, the regional Director of Mental Health & Addiction Services was appointed to the Vice-President's role on an interim basis.

The CEO reports directly to the RHA regarding the general and daily operations of the health region. The Executive Management Team is responsible for effective planning, integration and delivery of facility-based and community-based programs and services and reports directly to the CEO. The Executive Management Team is also responsible for the overall operation of the health region and provides executive sponsorship for seven lead Committees: Information Management, Communication, Quality Health Workplace, Quality, Utilization & Risk Management, Primary Health Care, Patient Care & Safety, Ethics and Health Emergency Operations. Sub-committees and working groups may function within each lead committee. Communication with the Management Network (regional directors, facility administrators, program and nursing managers) occurs through a combination of teleconferences and face-to-face meetings.

Within the Management Network, the resignation of the Director Information Management/Privacy Officer in November 2012 resulted in the expansion of the portfolio of the Director Information Technology to Director Information Management & Technology. Through a partnership agreement with the Saskatoon Health Region, privacy support and services for the region are being provided by the SHR Privacy & Access Office.

Governance

The terms of all 12 members of the Regional Health Authority officially expired on March 31, 2012. In April, RHA chairperson Wilf Veller resigned his position after serving three years on the Kelsey Trail Regional Health Authority. RHA vice-chairperson Rennie Harper assumed the role of the chair on an interim basis until board appointments were made in May 2012. The provincial government appointed seven members of the existing board to serve another term on the ten member Kelsey Trail Regional Health Authority (KTRHA), including Rennie Harper, Nipawin; Clarence Hendrickson, Carrot River; Gordon Cresswell, Tisdale; Frank Garchinski, Naicam; Dennis Koch, Melfort; Kathleen Bedard, St. Brieux; and Darrel Guy, Lintlaw. Rennie Harper was appointed chairperson and Clarence Hendrickson was appointed vice-chairperson. Three new members were appointed to the board, including Rhonda Desjarlais, Cumberland House; Richard Radom, Kelvington; and Nancy Steinbachs, Hudson Bay. Rhonda Desjarlais resigned from her position on the Board in December 2012.

The RHA is responsible for the planning, organization, delivery and evaluation of the health services it is directed to provide by the Ministry of Health. The RHA functions primarily as a "committee of the whole". There are four committees of the RHA: Quality Risk Management & Communications Committee, Finance & Audit Committee, Practitioner Liaison Committee, and the Governance Committee.

The RHA utilizes a broad range of informal consultations to gather information on community issues, needs and priorities related to healthcare. In addition to existing intersectoral relationships, the RHA and Executive have taken advantage of opportunities to meet with representatives of municipal councils and First Nations chiefs and councils to discuss health care concerns. Other informal consultation has involved discussions with the North East Regional Intersectoral Committee, community stakeholder groups, neighbouring school divisions, health region foundation and trust committees, and auxiliaries.

The health region utilizes a variety of formats to communicate with and engage the public. These include: regular monthly RHA meetings; community wellness assessments and other community-based events and activities; the external newsletter, the *KTHR Pulse;* the internal newsletter, *Coffee Break Conversation;* other publications including *Spotlight on Dental Health*, the *Primary Health Care Principle*, the *Volunteer Advantage* and *Hypertension Highlights* and several early childhood publications; the public website (www.kelseytrailhealth.ca); nine weekly and two regional, weekly newspapers; two community newsletters; and five radio stations. Regular contact with stakeholders and partners is maintained through a combination of email and regular mail distribution of publications. The RHA chairperson, CEO and other designated representatives are involved in presentations to municipal councils, community groups, partner agencies, community trust committees and/or foundations and the general public.

The KTHR Annual Report is produced and available in hard copy format and electronically through the region's website. The annual report is also accessible through the Ministry of Health website at www.health.gov.sk.ca/kelsey-trail-health-region.

Employee Demographics

The KTHR workforce includes 1,661 total employees (1,521 active) representing 1,195.94 full-time equivalents (FTEs). In total, almost 41% of the regional workforce is 50 years or older. The regional workforce is comprised of approximately 92% females. Seventy-four, or 6.2% of the region's FTEs have self-identified as Aboriginal since 2007-08.

A significant percentage of KTHR employees are long term. Sixty-two employees retired in 2012-13. In total, 140 current employees reached Rule of 80 retirement eligibility in 2012-13. Over the next two fiscal years, 112 more employees will reach Rule of 80 retirement eligibility.

The single largest challenge the region faces is recruitment and retention. In addition to physician recruitment and retention issues, the region experiences difficulty in recruiting and retaining Nurses, Nurse Practitioners, Therapists (occupational and physiotherapy), Pharmacists, Lab and Diagnostic Imaging Technicians. Labour shortages in any of these areas have the potential to impact patient, client and resident care. The recruitment and retention of GP/Obstetricians, GP/Anaesthetists and OR Nurses is also challenging and impacts the region's ability to provide labour and delivery services and deliver surgical services.

Emerging Health Issues

The health region works collaboratively with the Ministry of Health and Health Canada to maintain an awareness of emerging health issues. They are identified and addressed on the basis of priority.

A number of factors contribute to individual health. According to the World Health Organization (WHO) declaration, health is "a state of complete physical, mental and social well-being and not merely the absence of disease". The Determinants of Health impact the health of the individual.

Populations that are lacking or having difficulty accessing one of more of the determinants may be subject to disparities in health. Within KTHR, many people face challenges in accessing the resources that help achieve physical, mental and social well-being and directly impact overall health.

According to the Indigenous Peoples' Health Research

Determinants of Health

- *Income*
- *Social Support*
- *Education & Literacy*
- *Employment & Working Conditions*
- *Social Environments*
- *Physical Environments*
- *Personal Health Practices & Coping Skills*
- *Healthy Child Development*
- *Biology & Genetic Endowment*
- *Health Services*
- *Gender & Culture*

Health Canada

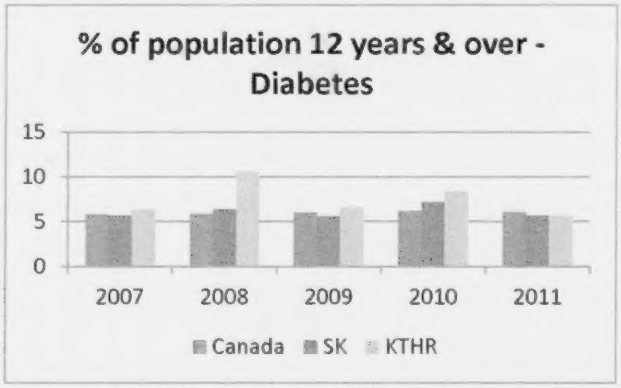
Centre, Aboriginal communities have identified their priority concerns as socio-economic status; mental health and addictions/trauma; and chronic disease – high rates of smoking and diabetes. Other issues of concern among the Aboriginal population have been identified as health care system access; the high incidence of sexually transmitted infections; Methicillin-Resistant Staphylococcus Aureus (MRSA), an antibiotic resistant staph infection; and the infant mortality rate.

Statistics Canada indicates the unemployment rate in the region (8.8%) is higher than both that of the province (5.0%) and the nation (7.5%). Educationally, 72.8% of the regions' population aged 25 to 29 are high school graduates which is lower than the provincial rate of 80.8% and the national rate of 86.7%. Among those aged 25 to 54, 45.2% are post-secondary graduates as compared to 54.7% provincially.

Adequate housing and diet are key determinants of health and the overall well-being of the population. The Northeast Housing Research Project revealed a shortage of rental stock and rental housing waiting lists in Melfort, Nipawin and Tisdale. For vulnerable, lower income populations, affordability is an issue. Economic and geographical issues impact diet among Aboriginal communities. Limited budgets reduce access to choice, quality and price of food resulting in poor diet choices that contribute to higher rates of diabetes and obesity.

In KTHR, obesity is becoming more prevalent among adults and youth with 67.7% of the population aged 18 and over considered overweight or obese as compared to 58.7% provincially and 60.3% nationally. Contributing factors include reduced activity, lack of family-eaten meals, increased access to convenience of fast foods, advertising, less homemade food and meals, limited or poor cooking skills, and food security issues. Obesity is linked to chronic diseases like hypertension, type II diabetes, cardiovascular disease, osteoarthritis and certain types of cancer. The Canadian Health Measures Survey: Physical Activity of Youth and Adults indicates just 7% of young people between 5 and 17 years of age attain the recommended minimum of 60 minutes of moderate-to vigorous physical activity on a daily basis, the minimum daily activity level recommended to achieve substantial health benefits.

Data from the Canadian Community Health Survey (CCHS), 2011 indicates the percentage of the population 12 years and over reporting they have been diagnosed by a health professional as having Type I or Type II diabetes has decreased slightly from 8.4% in 2010 to 5.7% in 2011. This figure includes females 15 and over diagnosed with gestational diabetes and is slightly lower than the national (6.1%) average. It is estimated more than half of type II diabetes cases could be delayed or prevented through healthier eating and increased physical activity. The Indigenous Peoples' Health Research Centre indicates an increase in diagnosis among First Nation and Métis populations and diagnosis appears to be occurring at a younger age.



Source: *Statistics Canada. Canadian Community Health Survey (CCHS), 2011*

In 2012, KTHR participated in the Ministry of Health: Audit of Prevention of Diabetes-related Health Complications. The objective of the audit was to assess whether the Ministry of Health, the Kelsey Trail Health Region and the Saskatoon Health Region had effective strategies for preventing diabetes-related health complications for the year ended March 31, 2012. The audit examined how effectively the Ministry develops and evaluates strategies and delivers programs for preventing diabetes-related health complications as well as the processes to collect data on their strategies and programs. It also examined how well KTHR and SHR deliver and evaluate programs to implement the strategies and their process to collect data on their programs.

KTHR was selected due to the relatively high prevalence rate of diabetes in the region and as an example of a mid-sized RHA in the province. According to the Ministry of Health, Population Health Branch information for the year ending March 31, 2011, KTHR has the third highest diabetes prevalence rate in the province at 69/1,000. The provincial average is 58/1,000. KTHR's Aboriginal population has an incidence rate twice as high as the provincial diabetes incidence rate. The prevalence of diabetes in the province and KTHR has gradually increased over the past ten years due to the fact that more people are being newly diagnosed with diabetes each year than are lost to death.

According to the findings of the audit, KTHR is providing programming based on initiatives from The Provincial Diabetes Plan 2004. KTHR has developed diabetes teams, relationships with primary health care teams, and networks with some medical specialists. The region is currently unable to assess the effectiveness of programming due to the absence of the systems necessary to collect data. There is currently no centralized information system to collect needed data related to diabetes. To facilitate effective program decision-making, the provincial auditor recommends the Ministry collect patient and cost information. The provincial auditor made four recommendations to the Ministry of Health related to the development of an information system for diabetes:

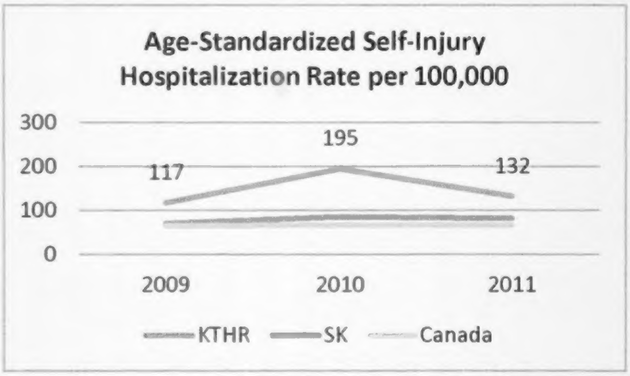
- Implementation of processes to accumulate, analyze and monitor provincial spending information on people with diabetes, and on diabetes-related complication prevention programs to assess the reasonableness of its resource allocations;

- Implementation of processes to gather sufficient information relating to people with diabetes and diabetes related health complications to ensure they are receiving care consistent with provincial standards;
- Collection and analysis of information to assess whether services delivered by physicians and care providers are effective and if they provide needed services to people with diabetes to prevent diabetes-related health complications; and
- Collection and analysis of information to assess the effectiveness of regional health authorities' programs to manage diabetes and the prevention of diabetes-related health complications.

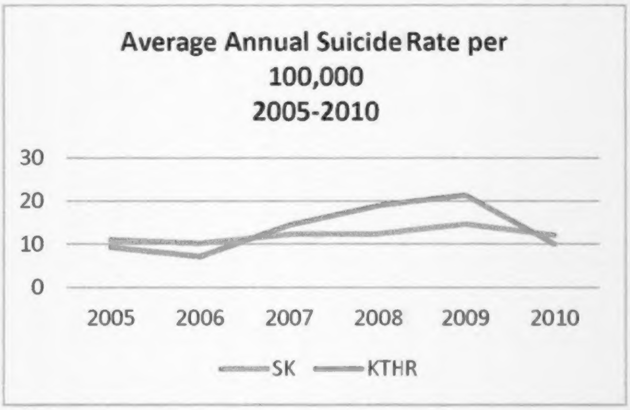
The audit findings indicate that in order to determine if regional programs are achieving the expected results the Ministry of Health must provide the region with current strategies, targets or guidance on resource allocations for diabetes service and prevention or reduction of diabetes–related health complications. The report's findings and recommendations were reported in the Legislative Assembly in the Provincial Auditor's 2012 Report – Volume 12.

Suicide and attempted suicide rates continue to be a concern in Kelsey Trail Health Region. Data from the Canadian Institute for Health Information indicates the region's age-standardized self-injury hospitalization rate of 132/100,000 is almost twice as high as the national rate and over 48% greater than the provincial rate of 81/100,000. Self-injury hospitalization rates in Kelsey Trail were the second highest in the province in 2011.

According to Statistics Canada, the rate of deaths due to suicides and self-inflicted injuries in Kelsey Trail is 10.0/ 100,000, slightly lower than the provincial rate of 11.2. Between 2005 and 2009, the region saw a 131% increase in the average annual suicide rate, moving from a rate of 9.3/ 100,000 to 21.5.



Source: *Canadian Institute for Health Information (CIHI)*



Source: *eHealth Saskatchewan*

KTHR's average annual suicide rates between 2006 and 2010 were higher than the provincial average. Suicide rates in northern Saskatchewan are almost double that of southern Saskatchewan, according to the 2011-12 Community Program Profile prepared by the provincial Ministry of Health's Community Care Branch.

According to 2012 Covered Population statistics, almost 20% of the region's population is 65 years of age and older, significantly higher than the provincial average. The population 80 years and over represents almost six percent of the region's total population.

The medical and psychosocial complexity of KTHR home care clients is increasing as are demands for services. In KTHR, 41.6% of the region's population over the age of 75 receives home care services. The highest proportion of home care clients are represented by those 80 to 89 years of age, similar to the province.

At 30, KTHR is providing the highest average home care services per client ratio in the province and is higher than the provincial average of 21.15, according to the 2011-2012 Community Program Profile. KTHR also has the highest rate of acute (30.2) and supportive care services (81.6), both of which are significantly higher than the provincial rates for acute (12.4) and supportive care (65.0).

Thirty-one percent of home care clients in KTHR, as compared to 23% provincially, are rated moderately impaired on the cognitive performance scale. Sixty-three percent of KTHR home care clients are considered either very high priority or high priority according to MAPLe tool evaluation, a decision support tool used to prioritize clients needing community or facility-based services. Clients' assigned very high priority are at high risk of adverse health outcomes. At the provincial level, 53% of home care clients fall in the same categories. MAPLe scores are considered a powerful predictor of admission to long term care and may indicate caregiver distress with higher scores indicating greater need for increased home care services and/or priority for placement for clients that cannot be managed at home.

Acute care discharges and the provincial surgical mandate are both impacting home care demand and workload. KTHR has the least amount of Personal Care Home (PCH) beds in the province per 1,000 population aged 75+ at 6/1,000. The next lowest region has more than two times the rate in KTHR. The provincial average is 42/1,000 population. Within the region, there are only two licensed personal care homes with the capacity to care for a total of 25 clients. The low number of personal care home beds impacts home care utilization as these clients still require care. If they cannot be admitted into long term care, this care is provided in the home or as alternate level of care in hospital.

As the level of care required by residents of long term care facilities evolves, there is a gradual increase in workload. Staff continue to be challenged with increased incidents of behavioural problems, aggression, wound care, palliative care and planning for demanding care.

Progress in 2012-13

The Ministry of Health develops and issues an annual document clarifying the performance relationship between the Ministry and the health region. The Accountability Document is focused on strategic directions for the health region and the Ministry's expectations for the region, complementing existing legislation, regulations, contracts, Ministerial directives and policies. All assumptions and accountabilities within the Accountability Document are prepared within the strategic priorities as outlined in the 2012-13 Health System Plan. Focusing on the 100 year strategies of better health, better care, better teams and better values, these areas of emphasis translate the region's vision, goals and priorities into a comprehensive set of performance measures and targets which provide a framework for achieving organizational improvement strategies directed at meeting the provincial three to five year outcomes as outlined in the 2012-13 Health System Plan.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve a 50% improvement in the number of people surveyed who say, "I can contact my primary healthcare team on my day of choice"

Results:

KTHR Project #1: Identify Clients at Risk for Suicide

- The overall rate for suicide in Kelsey Trail Health Region is 20 per 100,000 population (based on the Saskatchewan Health Service Utilization Reports, 2008-09).
- KTHR has one of the highest rates of suicide in the province for the 20-25 year age group.
- The impact on individuals is death, affecting families, friends and lost productivity. If death does not occur, there is potential for disability and repeated attempts.
- As a required operational practice, the Canadian Council of Health Facilities Accreditation standards require that the region assess and monitor patients for risk of suicide.
- Universal screening of all pre/postnatal women using the Edinburgh Postpartum Depression Scale (EPDS) has been implemented in KTHR through public health. Five screenings during the pre and postnatal period are recommended by the Provincial MotherFirst group.

- A provincial care guide has been developed for screening and referrals for mental health and community supports. The screening and referral package has been distributed to all physicians, NPs, Public Health Nurses, facilities and First Nations communities in KTHR.
- Beginning with a provincial alert in 2008, a provincial suicide task team has been working to develop standards of practice for all healthcare providers which are now ready for implementation. The recommendations include provision for training of all appropriate healthcare staff and that all patients/clients accessing healthcare be assessed for suicide risk.

Measurement Results:

By June 2014, eligible clients accessing health services will have a suicide risk assessment completed using the LivingWorks tools.

By December 2012, 95% of Nursing staff who have responsibility in the ER will receive Applied Suicide Intervention Skills Training (ASIST) training

By December 2012, 95% of general hospital Nursing staff and Nurse Practitioners will receive ASIST training

By April 2013, 95% of Licensed Practical Nursing (LPN) staff who work in an ER capacity will receive ASIST training

By April 2013, 60% of Home Care Nursing and Home Care LPN staff will receive ASIST/safeTALK training

100% of Public Health Nursing will receive safeTALK training

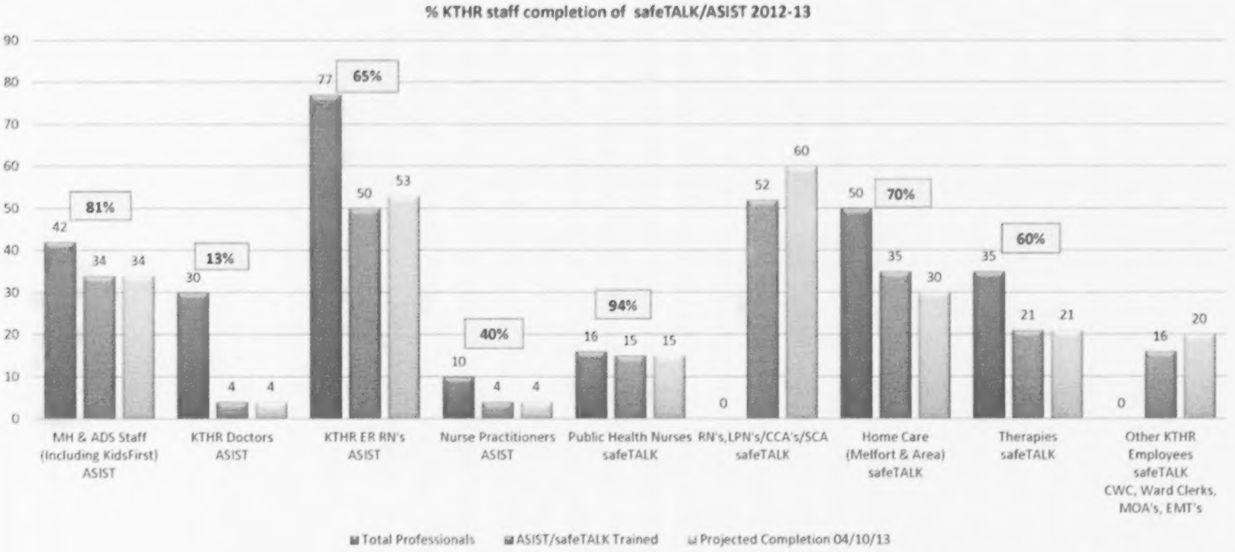
By April 2013, 60% of Therapies staff will receive safeTALK training

The region did not meet all of the targeted goals for the 2012-13 fiscal year largely due to limited human resource capacity to provide training. Eighty-one percent of KTHR MHAS staff, 13% of General Practitioners, 65% of ER RN's and 40% of Nurse Practitioners were trained in ASIST by March 31, 2013. The region met the targeted goal to train 60 percent of Therapies staff in safeTALK and almost reached the 100% targeted goal for Public Health Nursing, achieving a total of 94% of safeTALK training among this group of professionals. Fifty-two RN's, LPN's, CCA's and SCA's, 35 Home Care staff and 16 other KTHR staff received safeTALK training during the fiscal year however, the percentages of the respective staff represented is not available.

In addition to the KTHR staff that received safeTALK training, the KTHR facilitator was involved in training the Tisdale AAA Midget Trojans Hockey Club; several wellness leaders, youth and their parents from Rose Valley and Kelvington; and the North East Early Childhood Intervention Program (NEECIP), the first Early Childhood Intervention Program in the province to train all consultants. During the 2012-13 fiscal year, the three-hour safeTALK program was presented 22 times to a total of 223 KTHR staff and community members.

The two–day ASIST workshop was delivered five times during the 2012-13 fiscal year to 110 participants, which included KTHR physicians, NPs and ER RN's as well as six community members. In partnership with Prince Albert Grand Council, KTHR also delivered ASIST training to Red Earth First Nation and James Smith First Nation in the previous fiscal year.

All appropriate KTHR staff are being trained by the region's Population Health Educator, who is leading all safeTALK and ASIST training efforts for the health region. In the future, the health region would like to increase capacity through the training of another KTHR facilitator in the ASIST Training for Trainers. The current safeTALK trainer has applied for Instructor Training in an effort to provide more training opportunities for safeTALK facilitators within the region.



Source: *KTHR Population Health Coordinator Candace Rogers*

Improvement Target

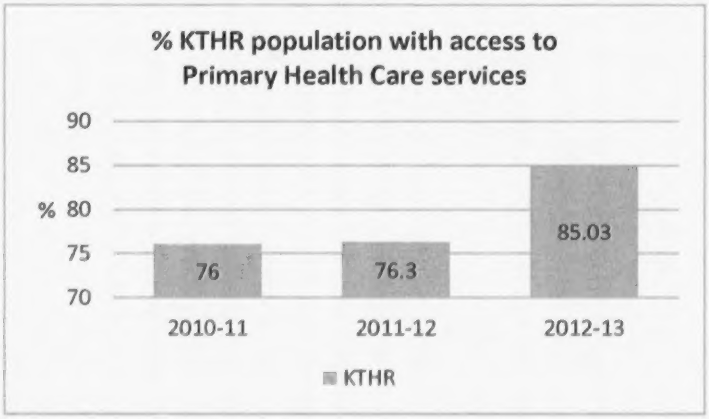
By 2015, all Saskatchewan residents who choose to be, will be connected to a primary healthcare team that includes or is linked to a family physician.

Results:

- Primary Health Care (PHC) services in Kelsey Trail Health Region expanded to Kelvington in 2012-13

Measurement Results:

By March 31, 2013, confirm/ establish a baseline by RHA of the percentage of clients connected to a primary health care team or provider and identify gaps in supply of primary healthcare providers



Source: *Primary Health Care Branch, Saskatchewan Ministry of Health*

With the expansion of Primary Health Care services to Kelvington, the percentage of clients with access to PHC services in KTHR increased to 85.03%. PCH sites at Arborfield, Carrot River, Cumberland House, Hudson Bay, Naicam, Nipawin (2), Porcupine Plain and Tisdale.

Improvement Target

By 2017, 80% of primary healthcare teams are engaged in clinical practice redesign

Results:

- Saskatchewan Health Quality Council (HQC) funded KTHR for a two-year Clinical Practice Redesign (CPR) position to coach and support all physician practices, all disciplines and office staff in their work to improve the client experience, office flow and efficiency.
- The initiative is being led by HQC and was designed in partnership with the Ministry of Health, Saskatchewan Medical Association, Regional Health Authorities, physicians, office managers, staff and patients.

Measurement Results:

By March 31, 2013, 100% of RHAs have initiated engagement of family physician practices and assessed readiness

By March 31, 2013, 100 primary healthcare teams and family physician practices are engaged in clinical practice redesign

Primary Health Care sites in Nipawin, Carrot River, Arborfield, Tisdale, Hudson Bay, Porcupine Plain, Naicam and Kelvington are all involved in clinical practice redesign to varying degrees. Initial contact has also been made with fee-for-service physicians in Melfort.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve a 50% reduction in the age-standardized hospitalization rate for ambulatory care sensitive conditions.

Improvement Target
By 2017, 75% of patients with chronic disease report an increase in confidence to self-manage their disease.
By 2017, 8% of patients are receiving care consistent with provincial standards for the five most common chronic diseases.

Results:

KTHR Project #2: Chronic Disease Management – Kidney Disease Management

- A reduction in regional chronic disease rates is necessary in order for KTHR to continue to meet patient and client needs with existing services and human resources. Reducing the rate of chronic disease will impact rates of patient mortality, morbidity and disability in KTHR.
- The Nipawin area, which includes Cumberland House, Shoal Lake and Red Earth First Nations, has twice the incidence of diabetes all other areas in the region.
- There is a need to develop cross-jurisdictional support to achieve success therefore initial effort will focus on Cumberland House.

- By December 31, 2012, the Chronic Disease Management/Kidney Care Team will improve coordination of care for people diagnosed with diabetes and kidney disease in Cumberland House as evident by increases to baselines scores in the Patient Assessment of Chronic Illness Care (PACIC) survey.
- Baseline PACIC scores were completed on nine patients in March 2012. Team members also completed the Assessment of Chronic Illness (ACIC) survey in March 2012 to identify areas of improvement in the Chronic Care Model.

Measurement Results:

By March 31, 2013, 80% of all people living in the Northern Village of Cumberland House and Cumberland House Cree Nation will be screened for renal insufficiency

By March 31, 2013, 75% of those with renal insufficiency will have appropriate follow-up and interventions as defined by current best practice guidelines

Though KTHR did not reach the 80% target, 67.5% of clients were screened for renal insufficiency. In total, 231 clients are participating in the project. Additional screening is required by 32.5% of clients. Cumberland House has been short-staffed for several months therefore, it has been difficult to ensure the amount of blood draws required. Plans to repeat the PACIC survey in December 2012 were delayed. Over the coming year, work will continue in Cumberland House in an effort to enhance the project before it is expanded to other locations within the region.

Milestones:

- A decision support tool regarding kidney health was developed
- Patients with Diabetes & Kidney Disease were identified
- Tracking system to monitor patients with Diabetes & Kidney Disease was developed
- Decision support tool for all clients with Diabetes & Kidney Disease was implemented
- All clinicians were trained on how to set kidney health goals with clients
- All clients with Diabetes & Kidney Diseases started setting goals
- Three clients were added to the Cumberland House Kidney Health Team
- Clients with Diabetes that have not had a kidney health screen completed in more than a year were screened
- Clients are starting to ask healthcare professionals about their blood work when they attend follow-up appointments

Improvement Target

By 2017, 80% of primary healthcare teams are using electronic medical records (EMR) that facilitate individual patient care and enable population-based reporting for quality improvement and planning.

Results:

KTHR Project #3: Primary Health Care – Electronic Medical Records Implementation

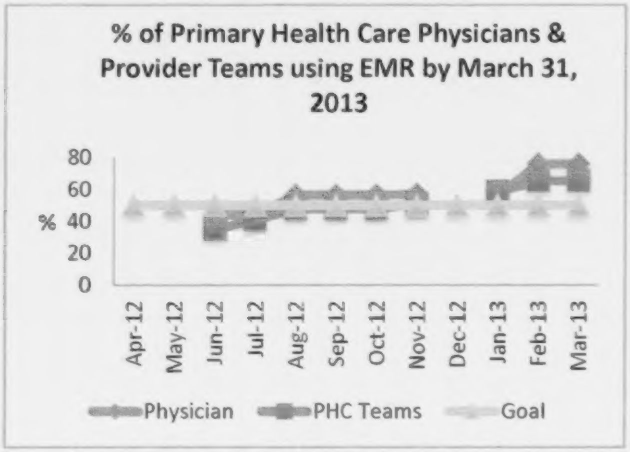
- Prior to April 1, 2012, there was no Electronic Medical Record (EMR) in healthcare clinics in Kelsey Trail Health Region.
- The absence of effective communication between healthcare providers places clients at risk of mortality, morbidity and disability.
- Through the implementation of EMR, community-based physicians and other Primary Health Care providers are able to store, retrieve and manipulate patient encounter information electronically, improving patient safety.
- No single software program was selected for implementation provincially. EMR implementation began in November 2012 with all fee-for-service physician clinics in Melfort. A different software program was used for implementation in PHC sites in the region.

Measurement Results:

By March 31, 2013, 50% of Primary Health Care physicians will be using the EMR

By March 31, 2013, 50% of Primary Health Care team members will be using the EMR

KTHR surpassed both targets, with 76% of Primary Health Care physicians and 65.3% of Primary Health Care Provider Teams using the EMR as of March 31, 2013. The "go live" date for the EMR at the Nipawin Health Centre and Nipawin Medical Group was March 27, 2013. Implementation at Smeaton, Arborfield, Carrot River and Tisdale progressed throughout 2012-13. The EMR will continue to roll out to the remaining Primary Health Care clinics in KTHR with


% of Primary Health Care Physicians & Provider Teams using EMR by March 31, 2013

Note: *No data was available April, May & December 2012*
Source: *Linda Barlow, KTHR Director Primary Health Care*

Cumberland House scheduled for 2013-14. Primary Health Care sites are in the scope of network and hardware support. All hardware is supplied by KTHR primarily through targeted PHC funding from the Ministry of Health.

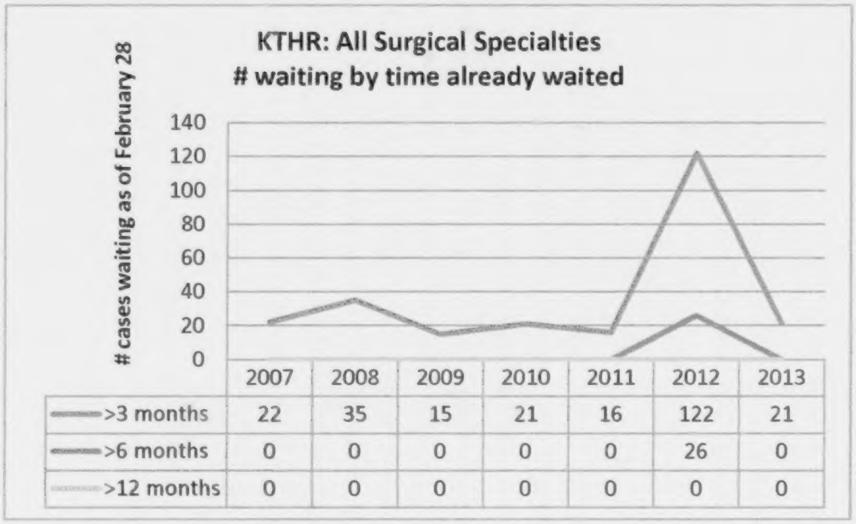
In May 2011, KTHR introduced the Lab Information System (LIS) to all six acute care sites. The implementation of the LIS positioned KTHR to become the first health region in the province to contribute patient lab results information from all acute care sites in the region to the new Saskatchewan Lab Results Repository when it was introduced in April 2012. The Repository became part of the existing components of the provincial electronic health record, which included the Pharmaceutical Information System (PIP) and the Picture Archiving & Communication System (RIS-PACS). The KTHR PACS moved to the provincial PACS in June 2012 as part of the second phase of the provincial RIS-PACS initiative. KTHR was the first health region in the province to connect all six acute care sites with a regional PACS in 2010.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome for all patients to be offered the option to have surgery within six months by March 31, 2013.

KTHR Results:

KTHR met the target for all patients to be offered the option to have surgery within six months by March 31, 2013.



	2007	2008	2009	2010	2011	2012	2013
>3 months	22	35	15	21	16	122	21
>6 months	0	0	0	0	0	26	0
>12 months	0	0	0	0	0	0	0

Source: *March 31, 2013 refresh of the SK Surgical Patient Registry data mart*

The region had no patients waiting more than six months for surgery this year, improving on the results of the previous fiscal year. The region also improved on the number of patients waiting more than three months for surgery, moving from 122 in 2012 to 21 in 2013. The majority of those waiting more than three months are dental or ophthalmology patients.

KTHR performed 92.2% of surgeries within six months, slightly better than the provincial average of 90%. The region performed 100% of surgeries within 12 months, higher than the provincial average of 97%. In total, Kelsey Trail performed 43.1% of surgeries within three weeks, 64.9% within six weeks and 81.2% within three months. No surgical wait times have exceeded 12 months in KTHR since 2007.

Improvement Target
By March 2013, 100% of expected surgical case volumes by region delivered

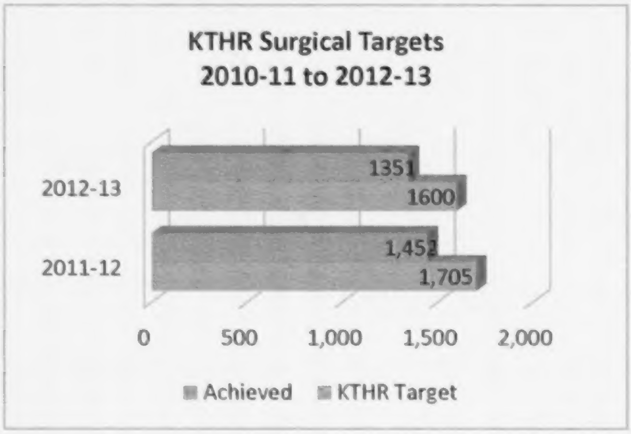
Results:

- KTHR's surgical results were impacted by a number of different factors:
    - The region reported 35 no shows and 39 cancellations during the fiscal year.
    - A number of surgeries that could have been performed in the region were scheduled in itinerant surgeons' home locations.
- Short notice cancellation of surgeries by itinerant surgeons and cancellation due to the region's inability to fill OR slates to capacity impacts patients as well as the region's budget.
- KTHR does not have the surgical volume and flexibility to best utilize staff and space by filling cancellations with other surgeries.
- If the no shows, cancellations and surgeries completed in itinerant surgeons' home locations would have been performed in KTHR the region would have completed 187 more surgical procedures in 2012-13, or 96% of the surgical target.

Measurement Results:

By March 2013, 100% of expected surgical case volumes by region delivered

KTHR was expected to complete a targeted volume of 1600 surgeries in 2012-13, 105 less surgeries than the previous year. The health region did not meet the surgical target, completing 84.4% of surgeries.



Source: *Ministry of Health Surgical Initiative Branch*

KTHR has taken action to address the issues associated with achieving the surgical targets and continues to recruit visiting surgeons. Discussions with existing itinerant surgeons have also been initiated to increase awareness of the financial impact current practices are having on patients and the region's budget.

Funding in the amount of $724,400 from the provincial government through the Saskatchewan Surgical Initiative supported KTHR with:

- the purchase and replacement of aging equipment;
- enhancing post-surgical home care services; and
- improving post-operative rehabilitation services.

The KTHR Therapies department completed 3,522 follow-up visits to surgical clients during the fiscal year.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve zero surgical infections from clean surgeries by March 31, 2017.

Improvement Target
By March 31, 2014 all surgeries in an Operating Room will use surgical safety checklists

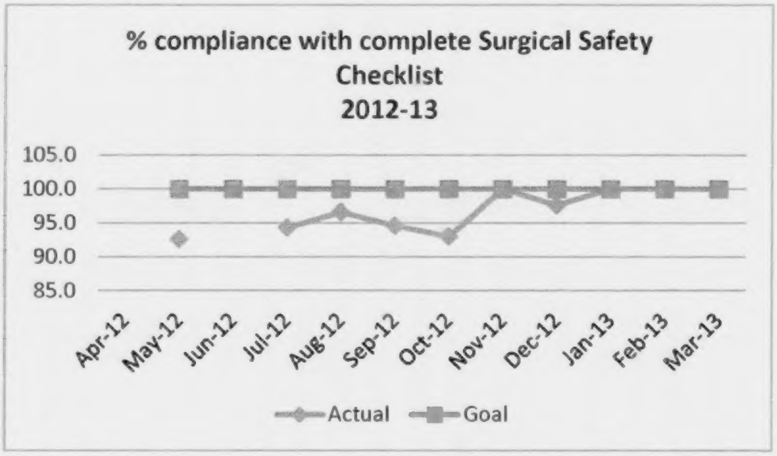
KTHR Project #4: Surgical Safety Checklist

Results:

- KTHR implemented the 3-part Surgical Safety Checklist during the 2011-12 fiscal year.
- Baseline data was established through a May 2011 audit which indicated zero compliance.
- Audit analysis indicated challenges meeting the briefing and debriefing components.
- Failing to wait for all participants to be present for the briefing component can put surgical patients at risk of adverse events such as wrong site surgery, wrong surgery, and even death. It can also result in significant delays in the OR.
- Adverse events can be easily prevented with 100 percent compliance with the Surgical Safety Checklist and will improve the patient experience, increase satisfaction and public confidence in the healthcare system, and decrease overall cost.

Measurement Results:

By March 2014, there will be 100% compliance in the use of the Surgical Safety Checklist in all KTHR facilities



Source: *Melody Dean, KTHR Regional OR Manager*
Note: *Data was not available for June 2012*

Quarterly completion results for the entire checklist report compliance rates of 92.6% in Q1, 95.2% in Q2, 96.7% in Q3 and 100% in Q4.

KTHR increased compliance rates significantly since 2011-12 and is moving closer to achieving the target by March 2014.

Challenges associated with compliance with the Surgical Safety Checklist include limited human resources and competing priorities:

- the region's resident surgeon and anaesthesiologists have patient care-related duties that take them out of the operating room in one facility
- waiting for all participants to be present during briefing can result in significant delays in the operating room

To address issues with compliance, changes have been made to the checklist for patients that only require local or standby anaesthesia. The OR Manager has worked with OR teams in Melfort and Nipawin to find solutions to address these issues, resulting in increased staff engagement which is reflected in improved audit compliance.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve no adverse events related to medication errors by March 31, 2017.

Improvement Targets
All RHAs and the Saskatchewan Cancer Agency will comply with Accreditation Canada's required organizational practices for medication reconciliation

By March 31, 2013, improve the process for medication reconciliation compliance audits in acute care
By June 30, 2012, begin compliance audits in long term care
By December 31, 2012, conduct a quality audit of MedRec at admissions to acute care

KTHR Project #5: KTHR reconciles clients' medications at admission and transfer or discharge in acute, long term care and home care services

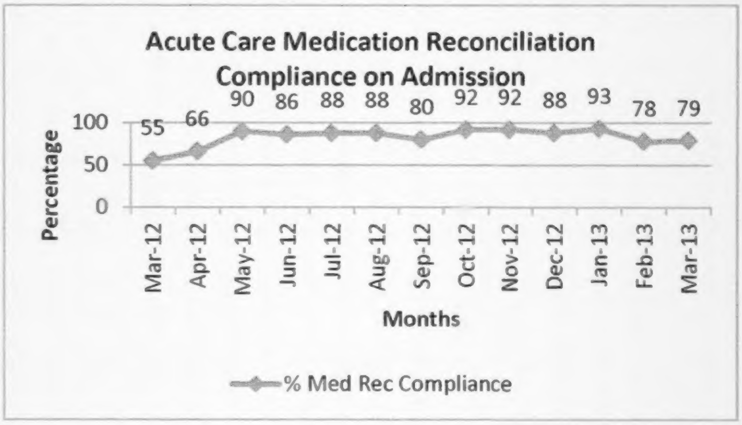
Results:

- The majority of the patients, clients and residents served in KTHR have chronic diseases managed by multiple medications.
- Medication regimes are often complex and have the potential for adverse drug events/errors resulting in ill health, hospitalization and risk of further injuries, such as falls.
- Over half of medication errors in hospital are related to admission, transfer and discharge.
- Almost three-quarters of inpatients have at least one medication discrepancy.
- Research indicates that medication reconciliation at transition points decreases harm to individuals, shortens length of hospital stay and reduces re-hospitalization.

Measurement Results: **Acute Care**

100% compliance on medication reconciliation of audited charts on admission and discharge from acute care by March 31, 2013

Zero discrepancies on audited charts by March 31, 2013



Source: *KTHR Kaizen Promotion Office*

By June 2012, all six acute care facilities in the region implemented medication reconciliation on admission. Medication reconciliation on discharge was implemented in all acute facilities by February 2013. Auditing of discharge is underway in all facilities.

All acute care sites have varying degrees of success with compliance but none reached and maintained the 100% compliance rate on a regular basis. Data from April 2013 indicates

75% compliance on medication reconciliation at admission. Most facilities are doing well on admission with one exception. In that facility, the nurse manager is working closely with staff and the pharmacy department to improve processes and remove barriers to successful completion. As of April 2013 compliance on discharge was 54%. A few facilities are still struggling with this process and it is being discussed as part of daily management on the nursing units.

Barriers to success include incomplete medication reconciliation on admission, physicians failing to identify a targeted date of discharge and lack of pharmacy support on weekends. Some of the issues with medication reconciliation on admission and discharge relate to transfers in and out of KTHR facilities.

Measurement Results: **Long Term Care**

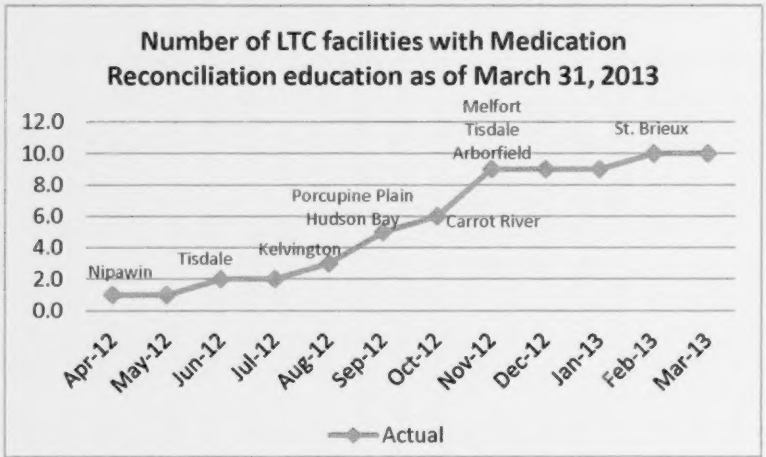
By December 2012, all long term care facilities in KTHR will have education on medication reconciliation

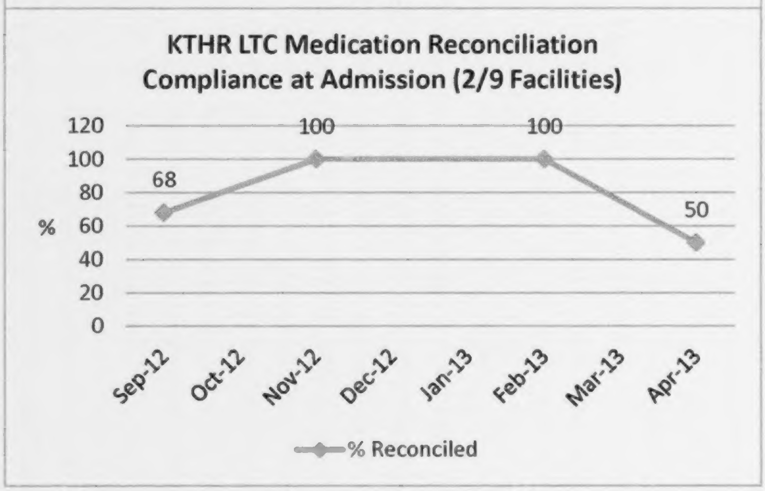
100% compliance on medication reconciliation of audited charts on admission and transfer from long term care by March 31, 2013

Zero discrepancies on audited charts by March 31, 2013

Staff in nine of the ten long term care facilities in KTHR received education and began implementing medication reconciliation by December 2012. Implementation at the last site began in January 2013.

The regional long term care audit process began in September 2012 with admissions. Audit data was collected from Pineview Lodge in Nipawin and from Newmarket Manor and Sasko Park Lodge in Tisdale.





Source: *KTHR Kaizen Promotions Office*

- Achieving targeted compliance rates has been impacted by trying to ensure staff are trained to follow standard work. Long term care clients come from other long term care facilities, acute care, community and other health regions. Standard work differs depending on where they come from and it can be challenging to obtain accurate medication histories.
- Physician access produces another challenge in achieving audit targets. Many of KTHR's more remote communities do not have resident physicians and must wait for the physician to visit the community. At times, this may not occur for one to three weeks, creating a batching system which may be forgotten by staff. Work with staff continues in an effort to address some of these barriers.

In June 2013, medication reconciliation audits on admission will be expanded to include the remaining long term care facilities within the region.

Measurement Results: **Home Care**

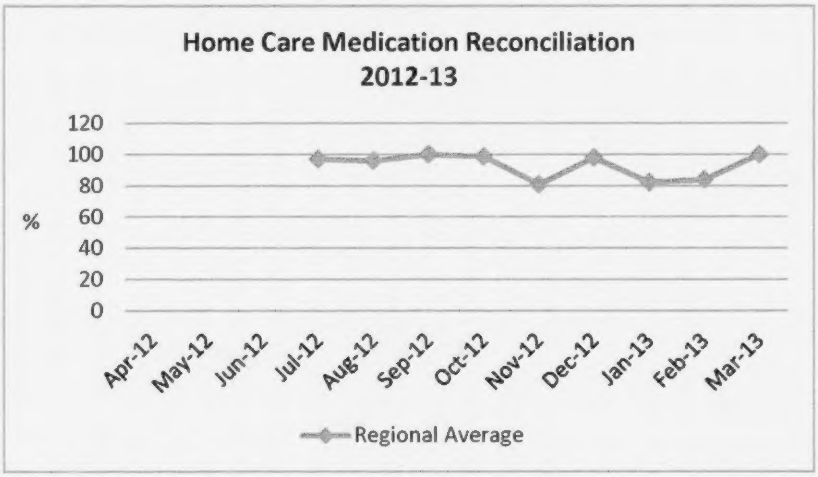
Individuals are compliant with their medication regime as agreed to between themselves and their prescriber

100% compliance on medication reconciliation upon admission for 2012

100% compliance on medication reconciliation upon discharge for 2013

Zero harm from inaccurate reconciliation of medications at transitions

Home care did not tabulate audit results for admission and discharge separately. The measurement used is the percentage of eligible clients with a reconciled medication list within one week. (Eligible clients include all new admissions into home care, current home care clients as scheduled for review and clients permanently discharged to long term care directly from home care.)



Source: *Sandy Weseen, KTHR Director Home Care*

- Implementation of medication reconciliation in home care required several small PDSAs (Plan Do Study Act) resulting in the creation of a standard work document which guides regional home care practices.
- Prescriber response to utilizing medication reconciliation has been very positive.
- Medication reconciliation in the home uncovered the use of many herbal medications which home care providers and the prescriber would have otherwise been unaware of, providing opportunities for client education.
- Home care utilizes the STOPP Beers list of medications to identify potential risks to clients.
- Medication reconciliation completed in hospital has contributed to decreased medication discrepancies when clients return home.

Among the challenges associated with the implementation of medication reconciliation in home care has been the integration with medical electronic heath records in one community. Because hard copies of medication reconciliation were not returned to home care, home care nurses were required to do more work and spend more time to assure that they had been viewed and acted on by the prescriber. Once it was confirmed that action had been taken, medication reconciliation was considered complete.

The goal to achieve 100% compliance of medication reconciliation on admission and discharge was not achieved in all sites. Implementation of the auditing process was staggered with some sites starting the auditing process in July 2012, some in November 2012, and one site completing its first audit in March 2013.

Some of the overall barriers and challenges associated with achieving 100% compliance in medication reconciliation in acute, long term and home care include:

- lack of understanding about the connection between potential patient harm as the result of failure to reconcile medications;
- the amount of time reconciling medications takes;
- trust in other systems that results in failure to reconcile mediations;
- does not correspond with technology; and
- duplication of work (medication reconciliation is completed with communities pharmacies, acute care, etc.).

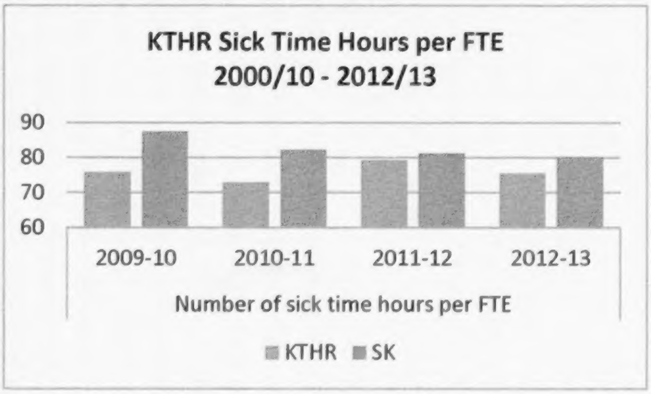
Better Teams

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve zero workplace injuries by March 31, 2017.

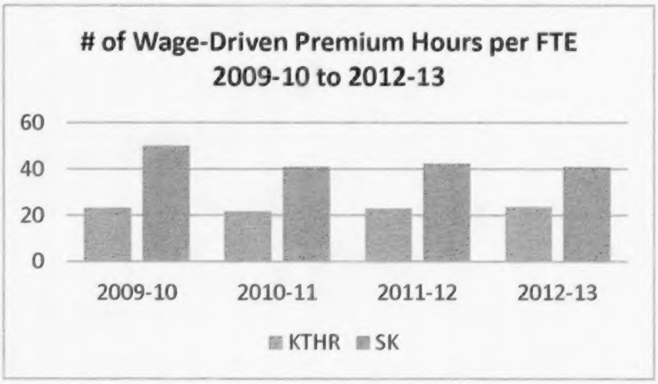
Improvement Targets
By March 2013, the Saskatchewan Association for Safe Workplaces in Health (SASWH) safety framework will be adopted
By March 2013, assessment will begin against the framework in areas with highest time loss and no time loss claims
By March 2013, a plan will be developed to address deficiencies in targeted areas

Results:

- During the 2012-13 fiscal year, the KTHR Attendance Support and Workplace Safety Strategy and Working Group focused on injury reduction and prevention.
- In the fall of 2012, KTHR re-established the Regional Occupational Health & Safety Advisory Committee. The main objectives of the committee are to eliminate workplace accidents/incidents; provide continuity of Safety Management Systems in support of OH & S programming and standards within the region; promote a regional culture of safety and to make recommendations in support of Safety Management Systems.
- Time loss Workers' Compensation Board (WCB) claims per 100 FTEs for the 2012-13 fiscal year were reported at 5.04, though data for the fourth quarter is incomplete. While less than the provincial rate of 5.14, KTHR's WBC claims are sixth highest among all RHAs and the SCA. The number of no time



Source: *RHA/SCA Profiles 2010-11 to 2012-13 Workforce Planning Branch*



Source: *RHA/SCA Profiles 2010-11 to 2012-13 Workforce Planning Branch* loss WCB claims per 100 FTEs recorded by the region was 4.15 over the same period, slightly higher than the provincial rate of 4.05 and the highest in the province.

- KTHR recorded 75.46 sick time hours per paid FTE in 2012-13, exceeding the regional target of 64. Compared to the previous year, KTHR recorded a 4.9% reduction in sick time hours per FTE, moving from 79.18 in 2011-12 to 75.46 in 2012-13. Provincially, KTHR has the fourth lowest sick time hours among the 12 health regions and is below the provincial rate of 80.31.
- KTHR exceeded the 2012-13 target of 17.17 for Wage-Driven Premium (WDP) hours per FTE, recording 23.49 during the fiscal year. Among the RHA's in the province, KTHR has the lowest WDP hours in 2012-13 however, WDP hours did increase by three percent compared to the previous year.

Overtime hours continue to be a concern for RHAs and the Ministry of Health. Overtime hours tend to increase during periods of peak utilization and often correlate with sick time. Overtime hours may also be associated with staffing shortages in hard-to-recruit areas.

KTHR is concentrating on facility-level action plans to address WDP hours. This includes root cause analysis and changing culture.

KTHR Project #6: Workplace Safety

Results:

- Healthcare has the highest workplace injury rate of any industry in the province.
- Kelsey Trail Health Region's injury rate is higher than the provincial industry code for healthcare organizations.
- Workplace injuries have a significant impact on employees' quality of life, adversely affect life inside and outside of the workplace, and employees' families. Every employee should be able to come to work and return home safely each day.
- KTHR piloted an initiative focused on improving workplace safety at Parkland Place, a long term care facility in Melfort.
- On June 14, 2012, Kelsey Trail Health Region CEO Glen Kozak signed the Saskatchewan Health & Safety Leadership Charter.
- In the fall of 2012, the KTHR Occupational Health & Safety Committee was re-established with representation from each local Occupational Health & Safety Committee in the region. Beginning the fall of 2012, the regional committee began meeting on a quarterly basis.
- In December 2012, a provincial Safety Management System (SMS) Framework was adopted.

- Regional OHS committees completed self-assessments against the provincial SMS Framework in January 2013. Gap analysis and the establishment of regional target areas followed in February 2013
- The Ministry of Labour Relations and Workplace Safety is proceeding with plans to implement Summary Offence Ticketing (SOT) for identified violations of the Occupational Health & Safety Act and regulations. Once fully implemented, the legislation will give Occupational Health Officers (OHOs) authorization to issue a SOT to organizations, supervisors and employees for violations of the Act and regulations.

Measurement Results:

KTHR will see a reduction of Transfer Lift & Repositioning (TLR) incidents at Parkland Place of 50% per month compared to the previous year and a cumulative reduction of at least 50% for the fiscal year by March 31, 2013

- **Employees of Parkland Place will be more engaged in workplace safety and will leave each shift without injury in the area of focus.**

100% of Occupational Health & Safety (OHS) committees will be represented at every Regional OHS meeting

Results:

- Due to a change of personnel in the Facility Administrator position in December, 2012, the Parkland Place initiative was not completed. While the initiative did create awareness about the focus on safety among staff at Parkland Place and provided opportunities to examine areas for improvement, due to competing priorities, staffing changes and capacity there has been no follow through.
- Provincial priorities related to reducing workplace injuries have changed to focus on safety-related training. Therefore, this project is being redefined. In the coming fiscal year, KTHR will focus on Safety Training for Supervisors and incident follow-up.
- Two OHS meetings were scheduled since the re-establishment of the regional committee. Attendance at the first meeting in November 2012 achieved 80% attendance at the second meeting in January 2014 was 65%. Attendance is impacted by winter travel conditions, the developmental stage of the committee, and competing priorities of committee members who are also Facility Administrators. In an effort to improve future attendance, some meetings will be scheduled as teleconferences to maximize participation opportunities for all members.

Better Value

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to ensure the healthcare budget increase amounts to less than the increase to provincial revenue growth, based on a five-year rolling average, by March 31, 2017.

Improvement Targets
By April 30, 2012, select a sensei/consultancy group
By March 31, 2013, establish standard Continuous Improvement Offices (regional and provincial) and supports to facilitate continuous improvement across the province
By March 31, 2013, engage a consultant in second cycle of Strategy Deployment transition to self-sufficiency
By March 31, 2014, complete 2 cycles (2012-13 and 2013-14) of Strategy Deployment, including the development of annual plans for short-term breakthrough initiatives and 3-5 year outcomes
By April 30, 2012,establish a robust cascading measurement system to report on the 2012-13 Breakthrough Initiatives, which includes the establishment of Visibility Walls and regular leadership review/huddles at the wall

Results:

KTHR Project #7: Building Lean Capacity

- Provincially, John Black & Associates (JBA) has been contracted to assist in the development and deployment of a lean management system in Saskatchewan. The process began in November 2011 with the introduction of the Hoshin Kanri strategic deployment process which established the provincial 100 year long term strategies, three to five year health system plan, provincial breakthrough initiatives, and regional breakthrough initiatives for the 2012-13 fiscal year.
- KTHR has no dedicated lean resources and must address this issue in order to meet the targets established in breakthrough initiatives.
- To date, the KTHR Management Network has only received a brief introduction to lean. The region will be working with provincial leadership to increase management capacity and create efficiencies.

Measurement Results:

Dedicate a minimum 3 FTE or the # required to deploy lean by August 30, 2012

Provide training through the provincial Lean Management System:

- **Lean certification**
- **Kaizen Basics**

Engage staff in Rapid Process Improvement Workshops (RPIWs)

Pursue provincial education and training opportunities

- Two existing Quality Improvement Coordinators in the KTHR Quality Department, in addition to the Director, were dedicated to deploying lean continuous improvement work in the region. No additional resources were added to the Quality department during the fiscal year. In February 2013, the KTHR Quality Department became the Kaizen Promotions Office (KPO).
- In the fall of 2012, the CEO, four Vice Presidents, the Director Quality, Director Acute Care Services, two Quality Improvement Coordinators and the RHA chairperson were among the region's ten seats confirmed to participate in the second wave of Lean Certification Training with the Saskatoon Health Region (SHR). Five of the ten participants were scheduled to participate in the North American Tour in May 2013. Five additional participant names have been submitted for participation in Wave 3 of Lean Certification Training with SHR beginning in July 2013.
- During the 2012-13 fiscal year, 72 KTHR employees completed Kaizen Basics training. Moving forward, KTHR has set a target to train 20% of staff in Kaizen Basics by March 31, 2014.
- The KTHR Management Network completed the second cycle of Strategy Deployment in December 2012. Based on input from the organizational-level Diagnosis & Review and Catchball sessions, health system leaders finalized the draft 2013-14 health system plan and refined the 2012-17 plan, proposing three provincial breakthrough initiatives for the 2013-14 fiscal year:
  - By March 31, 2014, improve access and connectivity in Primary HealthCare innovation sites and use early learnings to build foundational components for spread across the province;
  - Improving surgical access and transforming the surgical experience; and
  - Enhancing our safety culture with a focus on patient and staff safety.
- Based on the province's strategic priorities, KTHR selected two breakthrough initiatives for 2013-14:
  - Appropriate access to care for CTAS 4 & 5 in Melfort
  - Kelvington and area 3P project

- Visibility Wall Walks began with KTHR Level 2 leadership in June 2012. The Regional Visibility Wall has been established in Regional Office in Tisdale. The KTHR KPO facilitated the establishment of facility and department-based visibility walls as well as daily management. The KPO will be working toward creating an environment whereby quantitative, measureable improvement can be visualized and promoted in a meaningful and useful way for staff. Training and implementation of daily management as part of the work day in all facilities and departments began in March 2013 and will continue in 2014.
- In the 2013-14 fiscal year, additional training sessions will be offered to KTHR employees to assist in gaining understanding of lean continuous improvement. With the support of Health Quality Council (HQC), training opportunities for Kaizen Basics, 5S, Kanban and Value Stream Mapping will be scheduled for employees.
- Releasing Time to Care^{TM}, a quality improvement initiative KTHR introduced in 2010, transitioned into the provincial lean management system during the 2012-13 fiscal year. KTHR was involved in RTC in Nipawin Hospital and Melfort Hospital. The lean management system builds on RTC efforts.
- Challenges with meeting regional lean capacity targets are related to several factors.
    - Lean is a new concept to Saskatchewan and to healthcare.
    - There are conflicting priorities for resources within the region.
    - Managers do not currently have the capacity or knowledge to implement lean.
    - The existing healthcare culture does not yet support lean management.

KTHR Project #8: Capital Projects – Kelvington Integrated Facility

Results:

- KTHR received funding for the replacement of Kelvindell Lodge in Kelvington in February 2009. A schematic design package for the replacement of Kelvindell Lodge was developed at a cost which was not financially feasible for the municipal partners, who were responsible for 35 percent of the total project costs.
- Though a reduction in the municipal funding share required for health facility projects was announced in February 2012, the required 20 percent municipal share may jeopardize capital projects due to lack of affordability at the community level.
- KTHR is committed to lean quality improvement, a patient-centred approach to identifying and eliminating all non-value activities and reducing waste. Capital projects are considered lean priorities.
- Through the application of 3P (Production Preparation Process), a week-long process involving a team of health care providers, staff and patients, KTHR can ensure quality, safety, flow and efficiencies are built into capital project design. 3P involves team

development and testing of potential designs with a focus on optimizing flow among service areas and value from the patient perspective.

Measurement Results:

Receive approval from the Ministry of Health to apply 3P methodology to submitted projects by June 2012

- In July 2012, the Ministry of Health formally approved a shift in the scope of the Kelvington long term care replacement project to an integrated facility, which is expected to decrease the capital costs associated with the project and make it more affordable for municipal partners.
- John Black & Associates (JBA), a team of management consultants specializing in lean production, is leading lean continuous improvement work provincially, including the Kelvington Integrated Facility project.
- 3P is one of the lean tools being used in the design of the Kelvington project. Data collection to support the 3P took place in January and February 2013. The Kelvington 3P was held the week of March 4-8, 2013 involving teams of patients, clients, residents, families, physicians and staff.
- The 3P resulted in the creation of an initial draft concept design of a facility to best support the healthcare needs of the community now and into the future. The initial design will be revisited and tweaked at 30, 60 and 90 days intervals before a schematic design is developed, finalized and submitted to the Ministry of Health for approval. Two Rapid Process Improvement Workshops (RPIWs) resulting from the 3P are scheduled for May 13-17 and July 22-26, 2013 in Kelvington. Design and construction of the integrated facility presents the opportunity to shift to a new and innovative model of care utilizing a Primary Health Care (PHC) approach.
- Work on the Kelvington 3P will carry forward and has been selected as one of the region's breakthrough initiatives for the 2013-14 fiscal year.

Better Value

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to ensure the healthcare budget is strategically invested in information technology, equipment and facility renewal by March 31, 2017

Results:

- In March 2013, KTHR received approval for $116,000 in funding for two initiatives through the eHealth Transformation Fund. The eHealth Transformation Fund is designed to facilitate one-time funding for small information management, services and technology projects critical to the success of the health sector and in support of eHealth Saskatchewan's mandate.
- In total, eHealth reviewed 39 project submissions totalling nearly $4 million. The submissions were evaluated against criteria as well as demonstrated correlation to: initiatives in preparation or complementary to lean initiatives; alignment with provincial health system hoshins and outcomes; alignment to eHealth strategies; improvements to quality, cost, delivery, safety and morale; and sustainable infrastructure.
- In KTHR, the eHealth Transformation Fund approved initiatives are:
    - Uniprint: a print management solution to improve print functionality, provide secure print services and increase efficiencies in operations. This initiative is in alignment to current 3sHealth and eHealth Provincial initiative; and
    - Technology for Home Care Direct Service Providers: Increasing efficiency of Home Care field staff with improved technology to allow for real time updates of client information.
- Implementation of both initiatives will occur during the 2013-14 fiscal year.

Outcome Targets
By March 31, 2013 there will be ten million dollars in incremental savings for an accumulated total of 35 million dollars

Results:

- Health Shared Services Saskatchewan (3sHealth) was formally established in 2012.
- Key achievements for 2012-2013:
    - Establishment of the nine member 3sHealth Board of Directors.
    - Leveraged additional group purchasing contracts to increase buying power.
    - Implementing Global Healthcare Exchange (GHX), a software system to automate and streamline supply chain operations.
    - Continued work to enhance, automate and standardize human resource processes through Gateway Online.
    - Completed business case recommending a provincial linen strategy. The implementation of this strategy is expected to save the healthcare system $93 million over ten years.

- Received approval to proceed with the development of eight new business cases in the areas of laboratory services, diagnostic imaging, environmental services, supply chain, information technology and information management, enterprise risk management, capital projects and workflow optimization.

KTHR Results:

- KTHR exceeded regional targeted savings of $103,000, achieving $148,356 in savings in the areas of liability insurance, telecommunications and supplies during 2012-13.
- KTRHA chairperson Rennie Harper was appointed to the 3sHealth Board of Directors.
- Through Gateway Online, KTHR has fully implemented myPay (paperless earning statements), myInfo (personal data), and successfully launched myTalent (personal career-related information) in November 2012. The region is preparing for the implementation of myJob Postings (electronic job postings) in the fall of 2013.

KTHR Project #9: Workflow Management Self-Service: Reduce the amount of time spent processing employee-related data

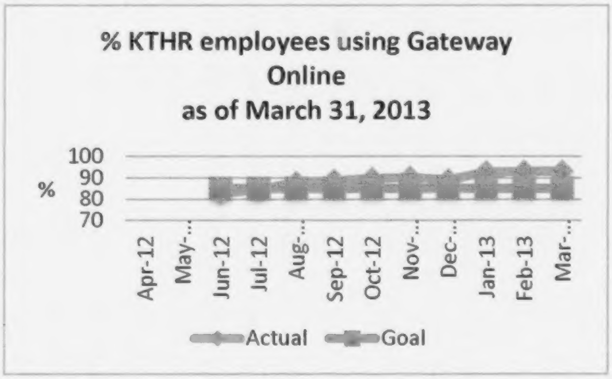
Results:

- Workflow Management Self-Service (WFMSS) is a provincial initiative focused on the standardization and automation of end-to-end human resources business processes. Dedicated change management resources are required to meet this initiative as it will directly impact every employee and manager within the health region and will have a profound effect on the way KTHR does business.
- The WFMSS project is scheduled for full provincial implementation by November 2013. This automated approach to business processes will create a seamless flow of information, gaining efficiencies through standardization and removal of duplication. Employees will have self-service capacity, known as Gateway Online (GO), for many functions reducing workload pressure points within the organization and increasing employee satisfaction. Managers will gain capacity through self-service and automated processes.

Measurement Results:

Between April 2012 and November 2013, dedicate a minimum of 3 FTE to complete the implementation of ESP (electronic scheduling program) in preparation for linkage with WFMSS

By March 31, 2013, 85% of employees are using the Gateway Online portal to access their information and complete self-service functions as measured through bi-weekly statistics on Gateway Online logins



Source: *3sHealth*

- ESP implementation is at 75% in KTHR. The region was unable to dedicate three FTEs to accomplish 100% implementation of the ESP due to a lack of available resources. In addition, significant variation in levels of computer literacy exists among employees and managers.
- In order to achieve five year outcomes, additional action is required to prepare for future breakthrough initiatives, including advance training of managers prior to implementation, regular assessment of usage and comfort level of the implemented bundle, and the provision of additional support and/or education as required. While not among breakthrough projects, the region continues to work on several actions in support of the provincial five year outcomes.
- KTHR exceeded the 85% target with 93% of employees initializing Gateway Online (GO) accounts as of March 31, 2013. KTHR recorded the highest GO account initialization among all RHA's in the province.

Supportive Actions

Intense focus and alignment with the strategic priorities in the 2012-13 KTHR breakthrough initiatives is intended to have a positive impact on achieving key provincial outcomes within a shorter timeframe. The regional breakthrough initiatives selected are priority areas of focus this fiscal year. Additional regional activities to support achievement of the provincial five-year outcomes were also undertaken during the fiscal year.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve a 50% reduction in the incidence of communicable disease (TB, HIV, STIs & MRSA) by March 2017

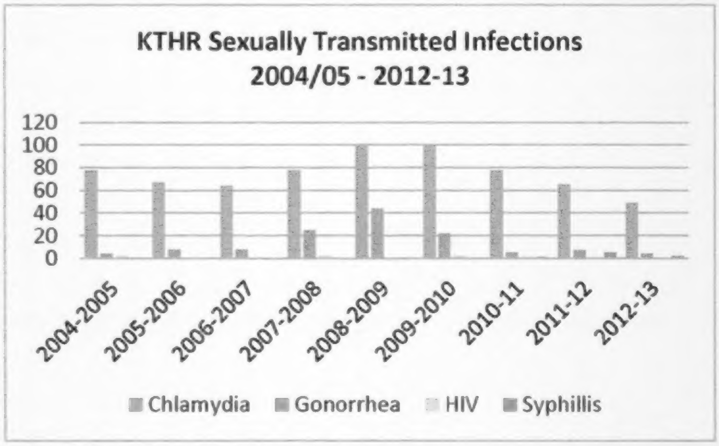
Results: HIV

- In 2012-13, no new cases of HIV were reported in KTHR. During the previous fiscal year, one new case was reported. In total, since the 2004-05 fiscal year KTHR has had eight reported HIV cases, ranging from zero to two new cases reported annually.
    - Epidemiology of HIV in Saskatchewan indicates an increasing trend of new HIV cases that are injection drug use-related.
    - Since 2005, Aboriginal women have accounted for a disproportionate number of female HIV cases under the age of 30.
    - There has been an increase in the number of HIV cases in males 30 years and older.

As part of the HIV Strategy for Saskatchewan 2010-14, the government committed annual provincial funding for community-based organizations, in collaboration with RHAs, to develop programs to assist in achieving the goals outlined in the strategy. KTHR Public Health and the Salvation Army (Melfort, Nipawin & Tisdale) received $3,000 in funding to support an HIV Awareness Support project. The project involved distribution and display of HIV pamphlets and a one day workshop on HIV awareness to train Salvation Army staff to provide assistance with educating clients about HIV, make referrals, provide emotional support, transportation or health referral appointments.

Results: Sexually Transmitted Infections (STI's)

- The number of Sexually Transmitted Infections (STI's) reported in the region has been gradually decreasing since peaking in the 2008-09 fiscal year. While the region has not completed any scientific analysis surrounding the decrease in the number of STI cases, it would appear the population is adhering to education provided by Public Health and is practicing safe sex or physicians are not testing for STIs and may be treating symptomatic cases based on clinical presentation. In either case, the number of lab positive STI's reported in the region would decrease.



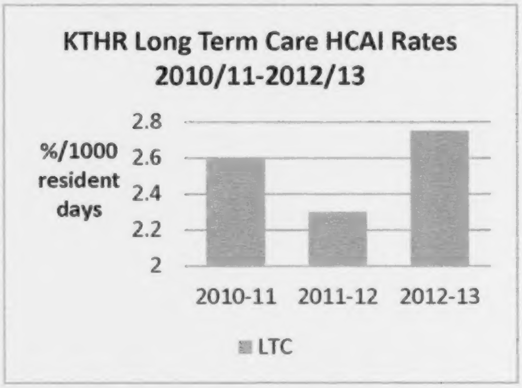
KTHR Sexually Transmitted Infections 2004/05 - 2012-13

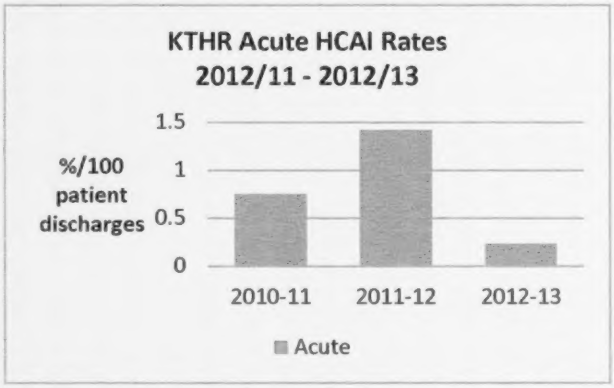
Source: *KTHR Communicable Disease/Immunization Coordinator 2012-13 Fiscal Year Report*

- The incidence rate for chlamydia has and continues to be the highest among all reported STI's in the region.
- There is a slight decline in the number of lab positive syphilis cases over the past two fiscal years. Within the past year mothers who tested positive for syphilis were successfully treated during pregnancy resulting in no health risk to the babies.
- The number of lab positive STI's is highest among the 15 to 35 year age group. In the previous fiscal year, STI infection rates were highest in the 20-25 year age group followed closely by the 15 to 19 year age group.

Results: ***MRSA***

- The volume of reportable incidents of MRSA in KTHR is very low.
- KTHR met compliance criteria for each infection control Required Organizational Practice (ROP) as evaluated by Accreditation Canada during the April 2011 Accreditation Survey, achieving 97% compliance for standards for Infection Prevention & Control (IPAC) and 95% compliance for standards for Reprocessing and Sterilization of Reusable Medical Devices.
- Targeted infection control funding from the Ministry of Health improved infection control standards with the KTHR dental program in Cumberland House.
- Hand hygiene auditor training was coordinated in partnership with the Saskatoon Health Region and offered in October 2012. The Infection Control Nurse works with Facility Administrators to increase hand hygiene auditing frequency in the region.
- Staff have the opportunity to participate in free online infection control education.


KTHR Long Term Care HCAI Rates 2010/11-2012/13


KTHR Acute HCAI Rates 2012/11 - 2012/13

Source: *KTHR Regional Infection Control Nurse*

- KTHR's Long Term Care Health Care Associated Infection (HCAI) rate appears to have increased over the past fiscal year but the statistics are influenced by changes in reporting. Historically, outbreak information was collected by resident case. Effective April 1st, 2012, outbreaks were included within the statistics per case. Public Health collects and provides outbreak information and the Infection Control Nurse includes cases in order to facilitate additional work on prevention strategies.

- The region's acute HCAI rate decreased significantly. Acute care has had few reported infections over the fiscal year with only one facility reporting a small cluster of infections that was contained. Increased attention to hand hygiene and audits influences HCAI rates in acute care.
- Provincially, work is being done in an effort to move reporting of HCAI's to patient days per resident days rather than a mix of 100 admissions and 1000 resident days. Measuring by 1000 patient days is not an accurate denominator in small, rural long term care facilities.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to provide seniors with access to supports that will allow them to age within their own home and progress into other care options as their needs change by March 31, 2017

Results:

- During 2012-13, the KTHR Access Review Committee (ARC) changed the manner in which clients awaiting long term care placement in acute care beds were dealt with. Clients assessed as requiring long term care and receiving extensive care from family/caregivers or family/home care support equal to the home care maximum of approximately 30 hours per week are now immediately placed on the transfer list. This allows the client to be supported in home by family with home care "topping up" their care until a long term care bed becomes available.
- KTHR chose to change this aspect of the ARC process for several reasons:
    - to acknowledge the care being provided by families and costs the region is not incurring as the result of this care;
    - to avoid duplication of work and the costs associated with being placed into the first available bed and then transferred;
    - to potentially decrease the home care workload, which can include maintaining the client at home by providing extensive services; and
    - to potentially decrease the number of Alternate Level of Care (ALC) days spent in hospital thereby decreasing the risk related to institutionalization for the individual while also increasing acute care bed availability.

- KTHR recognizes the potential risk associated with the change in the ARC process is an increased number of individuals on the transfer list.
    - Point in time data from the period October 1, 2012 to March 31, 2013 indicates 119 clients were offered placement in the first available bed during this period. In total, 910 days were waited by these clients. Clients waited an average of 7.65 days before they were offered the first available bed.

Measurement Results:

Measure: Reduce the number of individuals waiting for LTC in acute care

- KTHR did not meet the provincial target of 3.5% or less (average of 4.1 persons) of total acute care beds occupied by clients awaiting long term care placement by March 31, 2013, with an average of 5.5 persons or 4.74%. The region did make significant improvement in the third and fourth quarters, dropping to 2.25 and 3.3, respectively. The region improved significantly over the previous fiscal years average of 9.6% (average of 11 persons).
- KTHR places strong emphasis on discharge planning and timely assessments for patients awaiting long term care assessment and placement.
- This measure represents clients who have been assessed and accepted for long term care placement. It excludes any other alternate level of care clients who are no longer in need of acute care services, but remain in acute care waiting to be discharged to another appropriate setting.
- The number of ALC clients assessed and accepted by the ARC is tracked weekly to ensure clients presented are deemed acceptable for permanent placement.
- Though acute care services and patients are not impacted by the number of individuals waiting for long term care in acute care in the district hospital setting, staff workload is.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome for patients' ratings of exceptional overall healthcare experiences to be in the top 20% of scores internationally by March 31, 2017

Results:

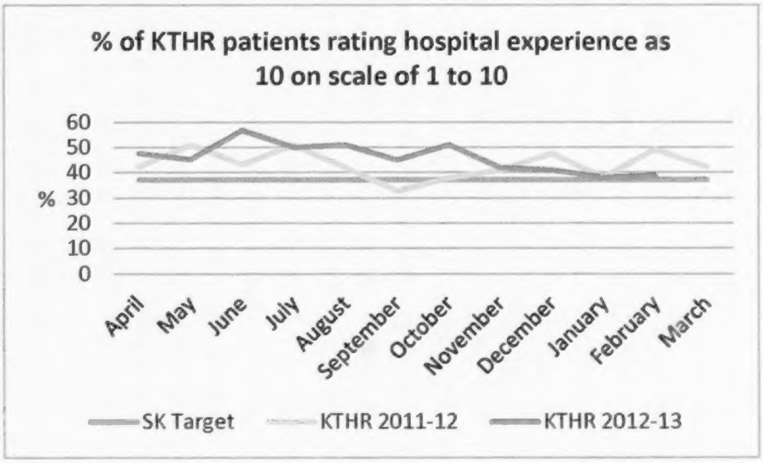
- The KTRHA approved the regional Patient & Family Centred Care (PFCC) implementation plan in March 2011.

- KTHR met the 2011-12 target to establish a baseline measurement for the Patient & Family-Centred composite by March 31, 2012 with a baseline of 74% which was higher than the provincial rating of 65%.
- Three patients shared their experiences with staff during KTHR's annual Canadian Patient Safety Week presentations in November 2012.
- In December 2012, KTHR began recruiting interested patients and families to participate in the Kelvington 3P in March 2013.
- KTHR initiated the client experience survey in response to the Ministry of Health's 2011-12 Strategic & Operational Directions for the Health Sector (SOD). The survey was piloted in acute, long term and primary care and was rolled out to all long term care sites in the region. Quarterly survey results serve as an indicator to target areas for improvement. The SOD measurement identifies the % of clients who indicate they feel that staff listened and respected them as a partner in their care by March 2017. KTHR established a target of 80% and results for the 2012-13 fiscal year indicate the region is currently surpassing the target at 88%. Laboratory Services, Diagnostic Imaging and Therapies are reviewing the survey for possible future implementation.

Patients rating hospital 10/10

KTHR Results:

Using baseline data from the Health Quality Council (HQC) Patient Experience Survey indicator, Kelsey Trail has consistently met or exceeded the provincial target of 37.1%, recording a mean rate of 46.1% for the period April 2012-February 2013. The region's performance this fiscal year was consistent with the previous year. With few exceptions, the percentage of patients rating their hospital experience as 10 on a scale of 1-10 in KTHR has consistently been above the provincial mean.



Source: *HQC Quality Insight*
Note: March 2013 data is unavailable

The regional Compassion in Action (CIA) program for employees was implemented in response to the 2009-10 Strategic and Operational Directions (SOD) of the Health Care Sector requiring the development and implementation of a Board approved plan for engaging the client.

% patients rating care they received in the Emergency Department as "excellent"

KTHR Results:

Between January and March 2011, Health Quality Council conducted an Emergency Department Patient Experience survey in which Melfort Hospital was one of the 14 pilot sites. Provincially, 21.6% of patients reported "excellent" overall care. Melfort Hospital exceeded the provincial average with 29.5% of unscheduled emergency department visits reporting excellent overall care.

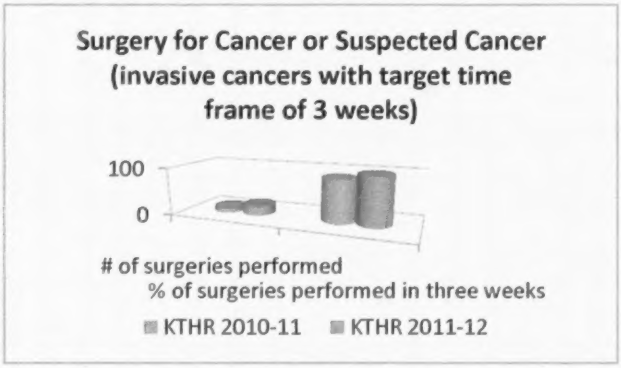
Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome for all cancer surgeries or treatments to be done within the consensus-based timeframes from the time of suspicion or diagnosis of cancer by March 31, 2015

% invasive cancer surgeries performed within 3 weeks

KTHR Results:

Based on the March 31, 2013 refresh of the Saskatchewan Surgical Patient Registry data mart, KTHR data for the 2012-13 fiscal year was supressed because less than 20 procedures were performed. In total, KTHR performed nine surgeries for cancer or suspected cancer during the fiscal year. Less than five patients are on the waiting list.



Surgery for Cancer or Suspected Cancer (invasive cancers with target time frame of 3 weeks)

Source: April 29, 2012 refresh of SK surgical patient registry data

In 2011-12, KTHR achieved 100% to exceed the target of 95% of invasive cancer surgeries to be performed within three weeks. In 2010-11, the region performed 88.9% of surgeries within three weeks. Provincially, in 2012-13 90% of cases were performed in 5.9 weeks.

Five surgeries for slower growing cancers with a timeframe of three months were completed in Kelsey Trail in the 2012-13 fiscal year, according to the March 31, 2013 refresh of the Saskatchewan Surgical Patient Registry data mart. Due to the low number of procedures, the percentage performed within the target timeframe was unavailable.

Better Teams

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome for the employee engagement provincial average score to exceed 80% by March 31, 2017

Number (%) of staff and clinicians trained in continuous improvement basics - Kaizen Basics

KTHR Results:

In total, 72 KTHR staff received Kaizen Basics training in 2012-13, representing 4.3% of the regions total staff. The region has established a target to have 20% of all KTHR staff trained in Kaizen Basics in 2013-14.

Number (%) staff dedicated to continuous improvement

KTHR Results:

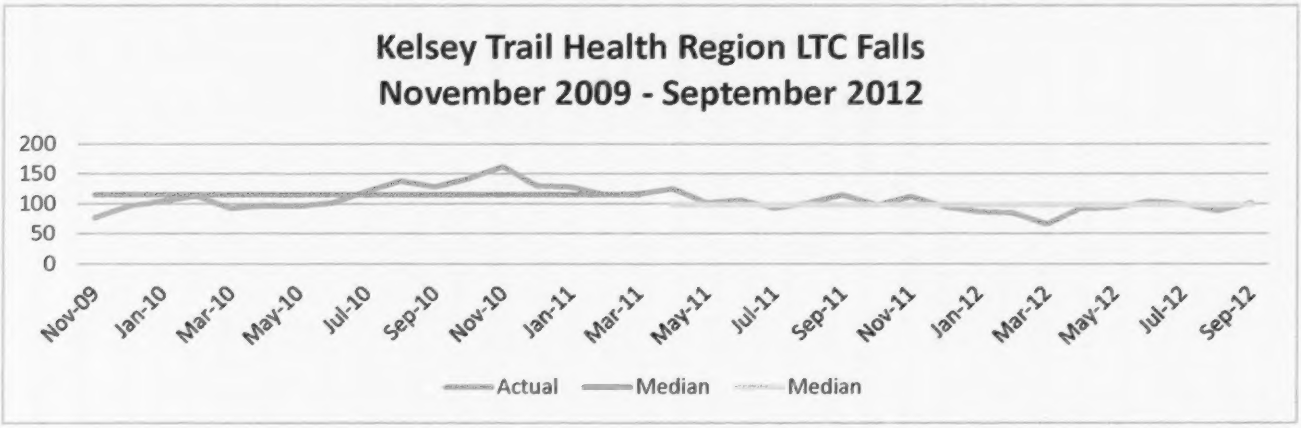
KTHR has 10 employees participating in lean certification training, which currently represents less than one percent of the region's total employees. Five more employees are scheduled to begin training in July 2013.

KTHR Patient First Progress

Number or percentage of long term care residents who experience a fall

KTHR Results:

- Falls and injuries associated with falls take a physical and emotional toll on patients and long term care residents. The cost of falls and injuries related to falls has a significant impact on the healthcare system. By focusing on prevention, the quality of life for patients and residents can be improved and, as a result, the cost to the health care system can be reduced.
- Regional efforts to reduce falls have resulted in significant improvement and is an ongoing priority for the region.
- Falls reduction work has become part of daily management for most long term care facilities and is a prominent feature on visibility walls across the region.



Source: *KTHR Client Incident Reports, November 2009 – September 2012*

- Regionally, KTHR achieved a 14% reduction in the median number of falls per month from November 2009 to September 2012. Though the region did not meet the regional goal to reduce the median by 20% by March of 2012, several long term care facilities in the region surpassed the goal. Among the facilities that experienced significant success in falls reduction were Hudson Bay Health Care Facility, which includes 22 long term care beds, and Red Deer Nursing Home in Porcupine Plain, which has 38 long term care beds.
- Hudson Bay Health Care Facility reduced their median number of falls per month by 45.5% while Red Deer Nursing Home reduced their median number of falls by 63%. Significant time and energy is committed to reducing falls and injury from falls. The KTHR falls reduction program was a featured presentation at the Quality Summit in April 2013.

Key to success is the individualized approach to care planning and addressing fall reduction on a resident-by-resident basis. The cumulative efforts of providing customized solutions that fit the needs of each high risk resident have resulted in the overall rate of reduction in falls achieved at the facility level and regionally.

Baseline data on long term care falls has been collected in KTHR since April of 2008 through client incident reporting forms. The data indicates what time most falls happen, where they happen, and contributing factors. This information is gathered and analyzed on a monthly and quarterly basis. While acknowledging there are some cases where falls cannot be prevented, mitigating the risk of injury is always the top priority.

KTHR achieved the target to have the *SaferHealthcareNow!* Falls Prevention Bundle implemented in 100% of long term care facilities by March 31, 2012, completing implementation in all 10 facilities in March of 2011. Several successful fall reduction interventions have been implemented.

- Monthly fall assessments
- Intervention strategy worksheets are used to track what interventions have been attempted, what has been successful and what has been unsuccessful. All necessary information is added to residents' care plans.
- Nursing staff have been trained in Gentle Persuasive Approaches (GPA) which decreases resident agitation and resistance to care, reducing the possibility of a fall. GPA helps staff understand what may be causing a residents' behaviour and agitation which assists in determining methods to de-escalate or avoid certain behaviours. It also makes staff more aware of how their behaviour influences residents' behaviour.
- PDSAs (Plan Do Study Act) resulted in the implementation of walking programs to increase mobility skills among residents, use of chair alarms and changes to better meet the nutritional needs of residents. Nutrition assessments revealed many residents were deficient in the areas of protein, dairy, and overall calories.
- Open lines of communication are maintained between staff, family and residents. Staff aware of safety issues can pass that information onto the families and families are encouraged to express any concerns they may have. All fall incidents are reported to the families of residents.
- Fall Reduction communication walls are visible to all staff and family members and include information on topics such as proper fitting shoes and walker height, and graphs on fall reduction results.
- Orthostatic blood pressures are taken, residents are supplied with and encouraged to wear anti-skid socks and standing orders for Vitamin D for ambulatory and high risk residents have been implemented.
- Resident footwear, foot condition, mobility aids and equipment is assessed on admission. TLR assessments are conducted to raise awareness regarding the setup in residents' rooms in regard to mobility and transfers.
- Beds with exit alarms have been relocated to the rooms of residents at risk of falling. Safety checks have been implemented whereby evening staff ensures all bed alarms have not been turned off during the day.

The progress made in fall reduction has also come with challenges.

- Not all staff believe in and take ownership of the program. Some of the interventions, such as the walking programs, require additional staff time and not all staff are convinced of the benefit the program has on reducing falls.

- Size and residents personal sock colour preferences can present barriers for some residents to wear anti-skid socks.
- There are competing demands on visiting Occupational and Physical Therapists' time among acute, long term care and community. Scheduled visits are often only two or three times per month.
- There is a concern that fall prevention will result in increased use of restraints on long term care residents.

In 2012-13, 34% of KTHR long term care residents experienced a fall or near-fall, a one percent increase over the previous year. Provincially, the average was 32%. KTHR averages remain consistent with provincial falls data. Reporting for this measure is based on data from the Minimum Data Set (MDS) assessments which are to be completed for all LTC residents. The data represents reductions in the number of falls but does not measure reductions in the number of individuals that have fallen.

Management Report

June 26, 2013

KELSEY TRAIL HEALTH REGION
REPORT OF MANAGEMENT

The accompanying financial statements are the responsibility of management and are approved by the Kelsey Trail Regional Health Authority. The financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity include amounts based on estimates and judgements. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority delegates the responsibility of reviewing the financial statements and overseeing Management's performance in financial reporting to the Audit & Finance Committee. The Audit & Finance Committee meets with the Authority, Management and the external auditors to discuss and review financial matters and recommends the financial statements to the Authority for approval. The Authority approves the annual report and, with the recommendation of the Audit & Finance Committee, approves the financial statements.

The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Audit & Finance Committee. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Glen Kozak
Chief Executive Officer

Shane Merriman
Chief Financial Officer

2012-13 Financial Overview

Kelsey Trail Health Region recorded an operational surplus, before interfund transfers, of $1,144,921. The region is required to make transfers from the operating fund to the capital fund for mortgage payments, the principal portion of the loan on the region's Energy Performance Contract, and necessary allocations to Maintenance & Replacement Reserves. Annualized transfers from operating to capital for the 2012-13 fiscal year amounted to $1,087,858 leaving an adjusted surplus after interfund transfers of $57,063. Kelsey Trail Health Region elected to transfer $375,000 to the capital fund to be used for capital equipment purchases.

The 2012-13 budget was based on budgeted revenues of $118,655,847, an increase of two percent over the previous year. Budgeted revenues include funding of salary increases for collective bargaining agreements with the Health Sciences Association of Saskatchewan (April 1, 2009 to March 2013). Salaries, benefits and medical remuneration account for 82.2% of KTHR's budget.

Budgeted expenditures increased by 2.14% over the same period, not including appropriations from the operating to the capital fund of 8.61% required for mortgage payments, the Energy Performance Contract Loan and SHC Reserves. The increase in expenses did not factor in actual and expected salary and benefit increases for the Saskatchewan Government and General Employees" Union (SGEU), the Saskatchewan Union of Nurses (SUN), out-of-scope employees and physicians.

The region was expected to achieve $1,185,000 in efficiency targets in 2012-13 to include:

- $5,000 in attendance support;
- $103,000 in shared services; and
- $1,077,000 in general efficiencies.

Attendance support strategies were developed in an effort to try to achieve the target of 64 sick time hours per FTE and 17.17 in wage driven premium hours per FTE (including overtime, third weekend worked and call back). While attendance support initiatives were included as part of the budget reduction strategy, achieving and sustaining all of the targets was difficult.

Though KTHR experienced a decrease in sick time hours per FTE, the region did not meet the target. KTHR's sick time rate remains below the provincial average. KTHR also did not meet the target for wage driven premium hours however, the region's rate was lower than the provincial average.

KTHR developed several initiatives designed to achieve the region's general efficiency target including administrative and supply savings through reductions in travel expenses through limiting out-of-region travel, using webinars, teleconferencing and Telehealth, and sharing travel. An improved hiring process and vacancy management continue to play an important role in achieving efficiencies. A comprehensive attendance management plan was developed to address sick time, overtime and WCB costs. Several quality improvement initiatives were undertaken through Lean in an effort to eliminate waste and create value for patients and clients. The region's financial viability continues to take priority and the region continues to make every effort to ensure change is managed with a focus on minimizing impact on patients while achieving efficiencies and best practices.

Several factors contribute to the region's operating pressures, particularly the growing costs associated with supporting current health services including:

- advances in technologies, procedures and drugs;
- increased emphasis on environmental/infection control, quality improvement and patient safety;
- human resources shortages, including physicians;
- recruitment costs and incentives required to remain competitive in the marketplace; and
- education and training of staff, both mandatory and other.

Regionally, services and processes continue to be reviewed in an effort to adopt best practice and achieve further efficiency. Strategies continue to be developed to achieve a balanced budget in 2013-14 in an effort to achieve long term sustainability and fiscal efficiency.

Capital equipment requests continue to surpass the capital funding available to the region. Advances in technologies, aging equipment and facilities impact the ability to meet the capital needs of the region. The 2012-13 capital budget of $3.5 million targeted new technology and equipment to address quality and patient safety. Priority items on the capital budget included additional surgical equipment to support the Saskatchewan Surgical Initiative (SKSI), ultrasound and diagnostic imaging equipment, block funding initiatives, and replacement of required capital equipment and ongoing work associated with the planning and construction of the long term care replacement projects in Kelvington and Tisdale.

KTHR has been working to complete its highest priority life safety/emergency and infrastructure needs with $3.8 million in infrastructure funding received through the provincial government's $1.5 billion *Ready for Growth* infrastructure initiative initially announced in 2008-09. The region has upgraded, replaced or installed nurse call systems, security systems, and fire alarms at a number of facilities. In addition to the safety equipment improvements, the region also completed work on emergency generators, heating and cooling systems, humidity control system, and building repairs and maintenance.

In 2012-13, the capital equipment funding allocation was $170,000 for general capital equipment. Equipment requests outweighed the funding available therefore, items were prioritized for budget consideration and contingency funds were established for urgent or emergent purchases during the fiscal year. Items that did not make the 2012-13 capital budget were added to the region's five-year capital equipment plan.

Community trusts, foundations and auxiliaries provide invaluable support to the region in providing financial resources to help meet capital equipment needs. In 2012-13, KTHR's three district hospitals in Melfort, Nipawin and Tisdale were the beneficiaries of a generous donation of $562,500 from The Orange Benevolent Society of Saskatchewan (OBS). Each facility received $187,500 directed at meeting the capital equipment needs for supporting pediatric and geriatric services.

The Tisdale Hospital and the Tisdale long term care replacement project, Newmarket Place, will benefit from a bequest in the amount of $820,000 from the estate of the late Lorne and Gizella Carson of Tisdale. In total, $410,448.24 of the bequest was designated strictly for the benefit of Tisdale Hospital for the purpose of purchasing equipment. The remaining $410,448.24 was designated strictly for Sasko Park Lode and Newmarket Manor for the purchase of equipment and furnishings. Sasko Park Lodge is in the process of being replaced through an addition and renovation to Newmarket Manor.

NeuPath Group, PC Inc.
Chartered Accountants

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Kelsey Trail Regional Health Authority

We have audited the accompanying financial statements of Kelsey Trail Regional Health Authority, which comprise the statement of financial position as at March 31, 2013, March 31, 2012 and April 1, 2011, the statements of operations, changes in fund balances and cash flow for the years ended March 31, 2013 and March 31, 2012, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design auditor procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Kelsey Trail Regional Health Authority as at March 31, 2013, March 31, 2012, and April 1, 2011, its results of operations, its changes in fund balances and its cash flows for the years ended March 31, 2013 and March 31, 2012, in accordance with Canadian public sector accounting standards.

NeuPath Group
Chartered Accountants

Nipawin, Saskatchewan
June 26, 2013

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2013

Statement 1

		Restricted Funds				
	Operating Fund	Capital Fund	Community Trust Fund	Total 2013	Total 2012 (Note 18)	Total 2011 (Note 18)
ASSETS						
Current assets						
Cash and short-term investments (Schedule 2)	$ 8,372,228	$ 4,878,290	$ 4,092,946	$ 17,343,464	$ 21,483,939	$ 26,729,507
Accounts receivable						
Ministry of Health - General Revenue Fund	89,000	2,536,860	-	2,625,860	99,027	-
Other	1,179,641	332,477	-	1,512,117	1,100,827	656,260
Inventory	574,194	-	-	574,194	584,197	538,265
Prepaid expenses	926,203	-	-	926,203	977,420	858,288
	11,141,265	7,747,627	4,092,946	22,981,839	24,245,410	28,782,320
Investments (Schedule 2)	1,221,325	-	-	1,221,325	1,187,993	1,116,152
Other assets	31,089	-	-	31,089	29,687	29,090
Capital assets (Note 3)	-	51,401,546	-	51,401,546	45,986,957	44,870,716
Total Assets	$ 12,393,679	$ 59,149,172	$ 4,092,946	$ 75,635,799	$ 71,450,047	$ 74,798,278
LIABILITIES & FUND BALANCES						
Current liabilities						
Accounts payable	$ 2,617,204	$ 496,922	$ -	$ 3,114,126	$ 3,768,588	$ 3,556,190
Accrued salaries	1,768,165	-	-	1,768,165	1,516,692	1,878,824
Vacation payable	6,958,007	-	-	6,958,007	7,208,000	6,731,728
Long term debt - current (Note 5)	-	643,113	-	643,113	612,670	652,038
Deferred revenue (Note 6)	2,579,224	-	-	2,579,224	2,184,304	2,246,150
	13,922,600	1,140,035	-	15,062,635	15,290,254	15,064,930
Long term liabilities						
Long term debt (Note 5)	-	9,446,340	-	9,446,340	10,110,046	12,128,820
Employee Future Benefits (Note 11)	4,149,100	-	-	4,149,100	4,187,700	4,244,700
Total Liabilities	18,071,700	10,586,375	-	28,658,075	29,588,000	31,438,450
Fund Balances:						
Invested in capital assets	-	41,312,093	-	41,312,093	35,264,242	32,089,858
Externally restricted (Schedule 3)	-	5,158,176	4,092,946	9,251,122	10,886,359	14,348,136
Internally restricted (Schedule 4)	-	2,092,529	-	2,092,529	1,446,531	1,768,794
Unrestricted	(5,678,021)	-	-	(5,678,021)	(5,735,084)	(4,846,960)
Fund balances – (Statement 2)	(5,678,021)	48,562,797	4,092,946	46,977,724	41,862,047	43,359,828
Total Liabilities & Fund Balances	$ 12,393,679	$ 59,149,172	$ 4,092,946	$ 75,635,799	$ 71,450,047	$ 74,798,278

Commitments (Note 4)
Pension Plan (Note 11)

Approved on behalf of the Board of Directors:

Harper

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2013

Statement 2

	Operating Fund			Restricted			
	Budget 2013	2013	2012 (Note 18)	Capital Fund 2013	Community Trust Fund 2013	Total 2013	Total 2012
REVENUES							
Ministry of Health - General Revenue Fund	$ 105,845,907	$ 106,920,353	$ 104,486,665	$ 4,576,000	$ -	$ 4,576,000	$ -
Other Provincial	1,842,209	1,639,425	1,251,027	338,008	-	338,008	333,958
Federal Government	25,000	30,614	28,021	-	-	-	-
Patient & Client Fees	8,510,190	8,344,301	8,294,611	-	-	-	-
Out of Province (reciprocal)	522,495	623,700	506,430	-	-	-	-
Out of Country	21,000	19,366	11,360	-	-	-	-
Donations	30,000	22,490	21,880	2,399,382	945,306	3,344,688	1,006,339
Ancillary	836,905	777,360	846,721	-	-	-	-
Investment	215,000	174,725	218,759	98,514	52,684	151,198	227,557
Recoveries	785,191	864,546	990,528	-	-	-	-
Research Grants	-	-	-	-	-	-	-
Other	21,950	120,182	42,652	-	-	-	-
Total revenues	**118,655,847**	**119,537,062**	**116,698,654**	**7,411,904**	**997,990**	**8,409,894**	**1,567,854**
EXPENSES							
Inpatient & resident services							
Nursing Administration	3,554,054	3,674,723	3,688,345	-	-	-	-
Acute	14,539,699	14,761,283	14,702,285	1,595,191	2,747	1,597,939	1,503,515
Supportive	18,034,123	18,048,104	17,781,890	1,319,030	45,629	1,364,658	1,498,605
Integrated	5,570,714	5,525,767	5,423,772	752,425	2,145	754,570	739,295
Rehabilitation	-	-	-	-	-	-	-
Mental Health & Addictions	-	-	-	-	-	-	-
Total Inpatient & Resident Services	**41,698,590**	**42,009,877**	**41,596,292**	**3,666,646**	**50,521**	**3,717,168**	**3,741,415**
Physician Compensation	**10,132,302**	**10,186,055**	**8,430,015**	-	-	-	-
Ambulatory Care Services	**3,170,235**	**3,090,743**	**3,023,860**	-	-	-	-
Diagnostic & Therapeutic Services	**11,241,558**	**10,831,026**	**11,019,869**	-	-	-	-
Community Health Services							
Primary Health Care	2,406,117	2,570,847	2,289,611	461,527	500	462,027	436,450
Home Care	7,587,294	7,633,560	7,683,276	-	-	-	-
Mental Health & Addictions	2,854,883	2,798,863	2,584,010	-	-	-	-
Population Health	5,318,080	4,975,349	4,892,403	-	-	-	-
Emergency Response Services	3,719,189	3,839,430	3,690,171	124,784	-	124,784	113,324
Other Community Services	593,064	593,701	575,226	34,583	-	34,583	30,634
Total Community Health Services	**22,478,627**	**22,411,750**	**21,714,697**	**620,893**	**500**	**621,393**	**580,408**
Support Services							
Program Support	6,458,441	6,748,866	6,259,250	-	-	-	-
Operational Support	22,313,601	22,712,153	22,835,861	100,579	-	100,579	141,232
Employee Future Benefits	-	(38,600)	(57,000)	-	-	-	-
Other Support	473,539	440,270	478,390	-	-	-	-
Total Support Services	**29,245,581**	**29,862,689**	**29,516,501**	**100,579**	-	**100,579**	**141,232**
Ancillary	-	-	-	-	-	-	-
Total Expenses (Schedule 1)	**117,966,893**	**118,392,140**	**115,301,234**	**4,388,118**	**51,021**	**4,439,140**	**4,463,055**
Excess (Deficiency) of Revenues over Expenses	**$ 688,954**	**1,144,922**	**1,397,420**	**3,023,785**	**946,969**	**3,970,754**	**(2,895,201)**
Interfund Transfers							
Building renovations (EPC Loan Payments)		(180,346)	(171,006)	180,346	-	180,346	171,006
Capital asset purchases			-	147,479	(147,479)	-	-
SHC reserves		(140,148)	(120,148)	140,148	-	140,148	120,148
Capital Equipment		(375,000)	-	375,000	-	-	-
Mortgage payments		(392,364)	(488,839)	392,364	-	392,364	488,839
Other (Mortgages - Paid Out)		-	(1,505,551)	-	-	-	1,505,551
Increase (Decrease) in Fund Balances		**57,063**	**(888,124)**	**4,259,123**	**799,490**	**4,683,613**	**(609,657)**
Fund balances, beginning of year		(5,735,084)	(4,846,960)	44,303,675	3,293,456	47,597,131	48,206,787
Fund balances, end of year		$ (5,678,021)	$ (5,735,084)	$ 48,562,797	$ 4,092,946	$ 52,280,743	$ 47,597,130

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year Ended March 31, 2013

Statement 3

	Operating Fund		Restricted Fund			
	2013	2012 (Note 18)	Capital Fund	Community Trust Fund	Total 2013	Total 2012
Cash Provided by (used in):	**Operating Activities**		**Financing and Investing Activities**			
Excess (deficiency) of revenue over expenditure	$ 1,144,922	$ 1,397,420	$ 3,023,785	$ 946,969	$ 3,970,754	$ (2,895,200)
Net change in non-cash working capital (Note 7)	(593,370)	(633,502)	(2,580,198)	-	(2,580,198)	132,537
Amortization of capital assets	-	-	4,088,098	-	4,088,098	3,927,322
Investment income on long-term investments	-	-	-	-	-	-
(Gain)/loss on disposal of capital assets	-	-	(3,699)	-	(3,699)	57,879
	551,552	763,918	4,527,986	946,969	5,474,955	1,222,538
Purchase of capital assets						
Buildings/construction	-	-	(7,850,680)	-	(7,850,680)	(3,512,624)
Equipment	-	-	(1,724,307)	-	(1,724,307)	(1,619,818)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	76,000	-	76,000	31,000
Sale (Purchase) of long-term investments	(34,733)	(72,439)	-	-	-	-
	(34,733)	(72,439)	(9,498,986)	-	(9,498,986)	(5,101,442)
Financing activities						
Long-term debt issued	-	-	-	-	-	-
Repayment of debt	-	-	(633,263)	-	(633,263)	(2,058,143)
	-	-	(633,263)	-	(633,263)	(2,058,143)
Net increase (decrease) in cash & short-term investments during the year	516,819	691,479	(5,604,263)	946,969	(4,657,295)	(5,937,047)
Cash & short-term investments, beginning of year	8,943,267	10,537,332	9,247,216	3,293,456	12,540,672	16,192,175
Interfund transfers (Statement 2)	(1,087,859)	(2,285,544)	1,235,337	(147,479)	1,087,859	2,285,544
Cash & short-term investments, end of year	$ 8,372,228	$ 8,943,267	$ 4,878,290	$ 4,092,946	$ 8,971,236	$ 12,540,672

The accompanying notes and schedules are part of these financial statements.

1. Legislative Authority

The Kelsey Trail Regional Health Authority (RHA) operates under *The Regional Health Services Act* (The Act) and is responsible for the planning, organization, delivery, and evaluation of health services it is to provide within the geographic area known as the Kelsey Trail Health Region, under section 27 of The Act. The Kelsey Trail RHA is a non-profit organization and is not subject to income and property taxes from federal, provincial, and municipal levels of government. The RHA is a registered charity under the *Income Tax Act* of Canada.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian Public Sector Accounting (PSA) standards, issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants (CICA). The RHA has adopted the standards for government not-for-profit organizations, set forth at PSA Handbook section PS 4200 to PS 4270. As these are the RHA's first financial statements prepared in accordance with PSA standards, Section PS 2125, *First-time Adoption by Government Organizations*, has been applied. The RHA has also chosen to early adopt Section PS 3450, *Financial Instruments*, as further explained in Note 18.

The RHA's financial statements were previously prepared in accordance with Canadian Generally Accepted Accounting Principles (Canadian GAAP), as set forth in Part V of the CICA Handbook. The impact of the transition from Canadian GAAP to public sector accounting standards is described in Note 18.

a) Health Care Organizations

i) The RHA has agreements with and grants funding to the following prescribed HCOs and third parties to provide health services:

Nipawin Oasis Community Centre Co-operative Ltd.
Kelvington Ambulance Care Ltd.
Tisdale Ambulance Care Ltd.
Shamrock Ambulance Care Ltd.
North East EMS
Melfort Ambulance Service
Town of Naicam

Note 9 b) i) provides disclosure of payments to prescribed HCOs and third parties.

ii) Fund Raising Foundations

The Nipawin Region Health Foundation Inc. and the North Central Health Care Foundation Inc. are incorporated under *The Non-Profit Corporations Act* and are registered charities under *The Income Tax Act of Canada*.

2. Significant Accounting Policies - continued

Under the Foundations' Articles of Incorporation, all funds raised by the Foundations after payments of reasonable expenses must be paid to the RHA (or must be used to purchase and transfer assets to the RHA, for the purpose to provide health care services.)

These financial statements do not include the financial activities of the two Foundations. Alternatively, Note 9 b) ii) provides supplementary information on the Foundations.

b) Fund Accounting

The accounts of the RHA are maintained in accordance with the restricted fund method of accounting for revenues. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the RHA including revenues received or receivable for provision of health services from the Ministry of Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the RHA in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received or receivable from the Ministry of Health – General Revenue Fund provided for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

iii) Community Trust Fund

The community trust fund is a restricted fund that reflects community generated assets transferred to the RHA in accordance with the pre-amalgamation agreements signed with the amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations in the RHA from donations or municipal tax levies. These assets are accounted for separately and use of the assets is subject to restrictions set out in pre-amalgamation agreements between the RHA and the health corporations.

c) Revenue

Unrestricted revenues are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant Accounting Policies – continued

Restricted revenues related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted revenues are recognized as revenue of the appropriate restricted fund in the year.

d) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Land improvements	1 - 20%
Buildings	2.5 - 10%
Equipment	3 – 33.33%

Donated capital assets are recorded at their fair value at the date of contribution (if fair value can be reasonably determined).

e) Asset Retirement Obligations

Asset retirement obligations are legal obligations associated with the retirement of tangible long-lived assets. Asset retirement obligations are recorded when they are incurred if a reasonable estimate of fair value can be determined. Accretion (interest) expense is the increase in the obligation due to the passage of time. The associated retirement costs are capitalized as part of the carrying amount of the asset and amortized over the asset's remaining useful life.

f) Inventory

Inventory consists of general stores, pharmacy, laboratory, linen and other. All inventories are held at the lower of cost or net realizable value as determined on a weighted average cost basis.

g) Employee Future Benefits

i) Pension

Employees of the RHA participate in several multi-employer defined benefit pension plans or a defined contribution plan. The RHA follows defined contribution plan accounting for its participation in the plans. Accordingly, the RHA expenses all contributions it is required to make in the year.

ii) Accumulated Sick Leave Benefit Liability

The RHA provides sick leave benefits for employees that accumulate but do not vest. The RHA recognizes a liability and an expense for sick leave in the period which employees render services in return for the benefits. The liability and expense is developed using an actuarial cost method.

2. Significant Accounting Policies – continued

h) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian Public Sector Accounting standards. In the preparation of financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates and assumptions will occur based on the passage of time and the occurrence of certain future events. The changes will be reported in earnings in the period in which they become known.

i) Financial Instruments

The RHA has classified its financial instruments into one of the following categories: fair value or cost or amortized cost.

All financial instruments are measured at fair value upon initial recognition. The fair value of a financial instrument is the amount at which the financial instrument could be exchanged in an arm's length transaction between knowledgeable and willing parties under no compulsion to act. The following financial instruments are subsequently measured at cost or amortized cost:

- Accounts receivable
- Short term and long term investments
- Accounts payable, accrued salaries and vacation payable
- Long term debt

As at March 31, 2013 the RHA does not have any material outstanding contracts or financial instruments with embedded derivatives. Financial assets are categorized as level 1 in the fair value hierarchy.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported in the statement of operations.

j) Replacement Reserves

The RHA is required to maintain certain replacement reserves as a condition of receiving subsidy assistance from Saskatchewan Housing Corporation. Schedule 4 shows the changes in these reserve balances during the year.

k) Volunteer Services

The operations of the RHA utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

3. Capital Assets

	2013			2012
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Land	$ 639,590	$ -	$ 639,590	$ 639,590
Land Improvements	687,297	645,479	41,818	72,972
Buildings	96,870,228	64,871,088	31,999,141	34,167,157
Equipment	25,334,023	17,651,050	7,682,973	7,538,293
Construction in progress	11,038,024	-	11,038,024	3,568,944
	$ 134,569,162	$ 83,167,616	$ 51,401,546	$ 45,986,957

4. Commitments

a) Capital Asset Obligations

As at March 31, 2013 contractual obligations for acquisition of capital assets were $7,698,905 (2012 - $15,224,481)

b) Operating Leases

Minimum annual payments under operating leases on property and equipment over the next five years are as follows:

2014	$151,590
2015	79,125
2016	53,410
2017	0
2018	0

c) Asset Retirement Obligations

The RHA has no recorded liabilities for asset retirement obligations (2012 - $0).

d) Contracted Health Care Organizations

The RHA continues to contract on an ongoing basis with private health service operators to provide health services in the RHA similar to those provided in the year ending March 31, 2012. Note 9 b) provides supplementary information on Health Care Organizations.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
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5. Long Term Debt

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2013	2012
Rose Valley Health Centre				
C.M.H.C., due October 1, 2021	4.54%	$43,335 Principal & interest Of which $11,063 is subsidized by SHC. Yielding an effective interest rate of 3.38%. Mortgage renewal date – February 1, 2015.	307,955	336,762
Newmarket Manor				
C.M.H.C., due March 1, 2023	4.54%	$160,042 Principal & interest Of which $41,658 is subsidized by SHC. Yielding an effective interest rate of 3.36%. Mortgage renewal date – February 1, 2015.	1,286,337	1,386,196
Kelvindell Lodge				
C.M.H.C., due October 1, 2020	5.14%	$37,003 Principal & interest Of which $11,621 is subsidized by SHC. Yielding an effective interest rate of 3.53%. Mortgage renewal date – December 1, 2013.	232,297	256,829
Red Deer Nursing Home				
C.M.H.C., due February 1, 2027	4.42%	$57,305 Principal & interest Of which $48,000 is subsidized by SHC. Yielding an effective interest rate of 0.72%. Mortgage renewal date – March 1, 2017.	596,415	626,925

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS
As at March 31, 2013

5. Long Term Debt – continued

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding	
			2013	2012
Arborfield Special Care Lodge				
C.M.H.C., due September 1, 2021	4.54%	$113,245 Principal & interest Of which $33,189 is subsidized by SHC. Yielding an effective interest rate of 3.21%. Mortgage renewal date – February 1, 2015.	798,285	873,847
Pineview Lodge				
C.M.H.C., due January 1, 2017	4.17%	$66,772 Principal & interest Of which $13,827 is subsidized by SHC. Yielding an effective interest rate of 3.31%. Mortgage renewal date – October 1, 2015.	236,307	292,072
C.M.H.C., due April 1, 2025	4.17%	$143,174 Principal & interest Of which $108,000 is subsidized by SHC. Yielding an effective interest rate of 1.02%. Mortgage renewal date – October 1, 2015.	1,359,734	1,444,893
Chateau Providence				
C.M.H.C., due October 1, 2026	4.31%	$96,109 Principal & interest Of which $70,650 is subsidized by SHC. Yielding an effective interest rate of 1.14%. Mortgage renewal date – December 1, 2016.	989,013	1,041,735
Energy Performance Contract				
Toronto Dominion Bank due October 15, 2026	5.33%	$413,885 Principal and interest	4,283,110	4,463,456
			10,089,453	10,722,715
Less: Current portion			643,113	612,670
			$ 9,446,340	$ 10,110,046

5. Long Term Debt – continued

Saskatchewan Housing Corporation (SHC) may provide a mortgage subsidy for supportive care homes financed by Canada Mortgage and Housing Corporation (CMHC). The subsidy may change when the mortgage renewal occurs.

For each of the mortgages, the RHA has pledged the related buildings of the special care homes as security. The term loan with the Toronto Dominion Bank is unsecured. Principal repayments required in each of the next five years are estimated as follows:

2014	$643,113
2015	691,327
2016	724,438
2017	759,184
2018	795,545
2019 and subsequent	6,475,846

6. Deferred Revenue

As at March 31, 2013	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Enhanced Dental Services	29,145	10,047	-	19,098
Infection Prevention and Control	52,780	31,632	46,085	67,233
Nursing Professional Development	7,858	7,858	-	-
Nursing Recruitment Funding	125,424	43,188	-	82,236
Physician Recruitment Pilot	100,000	50,000	-	50,000
Primary Care	958,128	7,714,169	7,716,749	960,708
Pharmacist Services	92,372	53,764	80,000	118,608
Surgical Initiative	186,000	87,120	337,585	436,465
Total Sask Health	**1,551,707**	**7,997,778**	**7,842,834**	**1,734,347**
Non Sask Health Initiatives				
Enhanced Dental Services	25,637	25,637	-	-
GST - Rebate Review	321,839	-	204,768	526,607
Kids First Targeted	249,069	496,599	565,800	318,270
Lean	36,052	36,052	-	-
Total Non Sask Health	**632,597**	**558,288**	**770,568**	**844,877**
Total Deferred Revenue	**$ 2,184,304**	**$ 8,556,066**	**$ 8,613,402**	**$ 2,579,224**

6. Deferred Revenue – continued

As at March 31, 2012	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Active Workplace Initiative	$ 3,533	$ 3,533	$ -	$ -
Alcohol & Drug Initiatives	23,162	23,162	-	-
Autism Services	102,038	102,038	-	-
Enhanced Dental Services	-	-	29,145	29,145
Infection Prevention and Control	11,580	3,852	45,051	52,780
Nursing Professional Development	12,099	4,241	-	7,858
Nursing Recruitment Funding	171,726	46,302	-	125,424
Pandemic	16,190	16,190	-	-
Patient and Family Centered Care	4,178	4,178		-
Physician Recruitment Pilot	103,080	3,080	-	100,000
Primary Care	599,112	6,426,983	6,878,372	1,050,500
Professional Development Funding	38,945	38,945	-	-
Quality Workplace Initiatives	38,625	38,625	-	-
Recruitment Initiatives	21,250	21,250	-	-
Safety Training Initiatives	78,794	78,794	-	-
Surgical Initiative	679,090	493,090	-	186,000
Total Sask Health	**1,903,402**	**7,304,263**	**6,952,568**	**1,551,707**
Non Sask Health Initiatives				
Enhanced Dental Services	-	18,813	44,450	25,637
GST - Rebate Review	-	-	321,839	321,839
Kids First Targeted	187,390	495,263	556,942	249,069
Lean	155,358	119,306	-	36,052
Total Non Sask Health	**342,748**	**633,382**	**923,231**	**632,597**
Total Deferred Revenue	**$ 2,246,150**	**$ 7,937,645**	**$ 7,875,799**	**$ 2,184,304**

7. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
	2013	2012	Capital Fund	Community Trust Fund	Total 2013	Total 2012
(Increase) Decrease in accounts receivable	$ (180,850)	$ (490,283)	$(2,757,275)	$ -	$ (2,757,275)	$ (53,311)
(Increase) Decrease in inventory	10,003	(45,932)	-	-	-	-
(Increase) Decrease in prepaid expenses	51,216	(119,130)	-	-	-	-
Increase (Decrease) in accounts payable	(831,539)	26,549	177,077	-	177,077	185,848
Increase (Decrease) in accrued salaries	251,473	(362,132)		-	-	-
Increase (Decrease) in vacation payable	(249,993)	476,272	-	-	-	-
Increase (Decrease) in deferred revenue	394,920	(61,846)	-	-	-	-
Increase (Decrease) in employee future benefits	(38,600)	(57,000)	-	-	-	-
	$ (593,370)	$ (633,502)	$(2,580,198)	$ -	$ (2,580,198)	$ 132,537

8. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2013 was $46,159 (2012 - $52,310). These amounts are not reflected in the financial statements.

9. Related Parties

These financial statements include transactions with related parties. The RHA is related to all Saskatchewan Crown Agencies such as ministries, corporations, boards, and commissions under the common control of the Government of Saskatchewan. The RHA is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the RHA is related to other non-Government organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts of transactions resulting from these transactions are included in the financial statements and the table below. They are recorded at exchange amounts which approximate prevailing market rates charged by those organizations and are settled on normal trade terms.

In addition, the RHA pays Provincial Sales Tax to the Saskatchewan Ministry of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2013	2012
Revenues		
Athabasca Regional Health Authority	$ 141,879	$ 136,691
Ministry of Education	640,565	630,530
Ministry of Justice	100,000	125,000
Sask Housing Corporation	338,008	333,958
SGI	95,506	78,065
	$ 1,315,957	$ 1,304,243

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
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9. Related Parties - continued

Expenditures		
Correctional Facilities Industries Revolving Fund	$ -	$ 792
Cumberland Regional College	1,600	3,004
Health Quality Council	6,549	-
Heartland Health Region	145	-
Mamawetan Churchill River Regional Health Authority	8,220	-
Ministry of Central Services	599,332	605,824
North East School Division	44,261	29,446
North Sask Laundry & Support Services	688,310	701,074
Prairie North Regional Health Authority	-	90
Prince Albert Parkland Regional Health Authority	15,414	2,093
Regina Qu'appelle Regional Health Authority	53	248
3sHealth	3,813,964	3,616,636
Sask Energy	1,145,083	1,098,852
Sask Housing	55,086	1,514,770
Sask Power	1,139,047	1,346,609
Sask Rivers Public School Division	65	-
Sask Tel	767,397	722,667
Sask Workers Compensation Board	1,925,766	943,325
Saskatchewan Institute of Applied Science and Technology	3,778	5,531
Saskatchewan Transport Company	13,304	18,110
Saskatoon Regional Health Authority	339,321	319,637
SGI	10,452	8,250
SHEPP	10,469,414	10,158,025
Sunrise Regional Health Authority	402	8,464
Community Initiatives Fund	-	127
Cyress Regional Health Authority	-	62
eHealth Saskatchewan	204,256	113,273
Five Hills Regional Health Authority	81	272
Holy Trinity School Division	-	2,048
Horizon School Division	-	157
Physician Recruitment Agency of Saskatchewan	110	150
Saskatchewan Research Council	348	348
	$ 21,251,756	$ 21,219,883

9. Related Parties - continued

	2013	2012
Accounts Receivable		
Ministry of Health	$ 2,625,861	$ 99,027
	$ 2,625,861	$ 99,027
Prepaid Expenditures		
Workers Compensation	$ 322,376	$ 350,072
	$ 322,376	$ 350,072
Accounts Payable		
Ministry of Health	$ 181,034	$ -
	$ 181,034	$ -

b) Health Care Organizations

i) Prescribed Health Care Organizations and Third Parties

The RHA has also entered into agreements with prescribed HCOs and Third Parties to provide health services.

These organizations receive operating funding from the RHA on a monthly basis in accordance with budget amounts approved annually. During the year, the RHA provided the following amounts to prescribed HCOs and Third Parties:

	2013	2012
Nipawin Oasis Community Centre Co-operative Ltd.	56,752	42,736
Kelvington Ambulance Care Ltd.	419,495	461,833
Tisdale Ambulance Care Ltd.	495,131	496,636
Shamrock Ambulance Care Ltd.	233,892	237,082
North East EMS	1,021,285	1,027,437
Melfort Ambulance Service	503,431	500,867
Town of Naicam	154,055	123,394
	$ 2,889,985	$ 2,889,985

ii) Fund Raising Foundations

Fund raising efforts are undertaken through non-profit business corporations known as the Nipawin Region Health Foundation Inc. and North Central Health Care Foundation Inc. The Kelsey Trail Regional Health Authority has an economic interest in the Foundations. In accordance with donor-imposed restrictions, $272,835 (2012 - $322,017) of the foundations' net assets must be used to purchase specialized equipment or services. The Nipawin Region Health Foundation Inc. total expenses include contributions of $54,353 (2012 - $151,624) to the RHA. The North Central Health Care Foundation Inc. total expenses include contributions of $0 (2012 - $71,570) to the RHA.

10. Comparative Information

Certain prior year comparative balances have been reclassified to conform to the current year's presentation.

11. Employee Future Benefits

a) Pension Plan

Employees of the RHA participate in one of the following pension plans:

1. Saskatchewan Healthcare Employees' Pension Plan (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Health Shared Services Saskatchewan (3sHealth) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multi-employer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the 3sHealth Board of Directors).

2. Public Service Superannuation Plan (PSSP) (a related party) - This is also a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. Public Employees' Pension Plan (PEPP) (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to these plans is limited to making required payments to these plans according to their applicable agreements. Pension expense is included in Compensation – Benefits in Schedule 1 and is equal to the RHA contributions amount below.

	2013				2012
	SHEPP[1]	PSSP	PEPP	Total	Total
Number of active members	1,356	-	8	1,364	1,362
Member contribution rate, percentage of salary	70%-10.00%	5.40%	6.00-7.00%*		
RHA contribution rate, percentage of salary	62%-11.20%	22.09%	6.00-7.00%*		
Member contributions (thousands of dollars)	4,937	1	38	4,975	4,860
RHA contributions (thousands of dollars)	5,529	5	38	5,571	5,440

*Contribution rate varies based on employee group

[1] Active members are employees of the RHA, including those on leave of absense as of March 31, 2013.
Inactive members are not reported by the RHA, their plans are transferred to SHEPP and managed directly by them.

11. Employee Future Benefits - continued

b) Accumulated Sick Leave Benefit Liability

The cost of the accrued benefit obligations related to sick leave entitlement earned by employees is actuarially determined using projected benefit method prorated on service and management's best estimate of inflation, discount rate, employee demographics and sick leave usage of active employees. The RHA has completed an actuarial valuation as of March 31, 2013. Key assumptions used as inputs into the actuarial calculation are as follows:

	2013	2012
Discount rate	2.50%	2.75%
Earnings Increase	0% - 2%	0% - 2%

		2013		2012
Accrued benefit obligation, beninng of year	$	4,187,700	$	4,244,700
Cost for the year		591,900		567,300
Benefits paid during the year		(630,500)		(624,300)
Accrued benefit obligation, end of year	$	4,149,100	$	4,187,700

12. Budget

The RHA Board approved the 2012-2013 budget plan on June 5, 2012.

13. Financial Instruments

a) Significant Terms and Conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing, and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Financial Risk Management

The RHA has exposure to the following risk from its use of financial instruments: credit risk, market risk and liquidity risk.

13. Financial Instruments - continued

The Chairperson ensures that the RHA has identified its major risks and ensures that management monitors and controls them. The Chairperson oversees the RHA's systems and practices of internal control, and ensures that these controls contribute to the assessment and mitigation of risk.

c) Credit Risk

The RHA is exposed to credit risk from the potential non-payment of accounts receivable. The RHA is also exposed to credit risk from cash, short-term investment and investments.

The carrying amount of financial assets represents the maximum credit exposure as follows:

		2013		2012
Cash and short-term investments	$	8,372,228	$	8,971,236
Accounts receivable				
Ministry of Health - General Revenue Fund		2,625,860		99,027
Other		1,512,117		1,100,827
Investments		1,221,325		1,187,992
	$	13,731,530	$	11,359,082

The RHA manages its credit risk surrounding cash and short-term investments and investments by dealing solely with reputable banks and financial institutions, and utilizing an investment policy to guide their investment decisions. The RHA invests surplus funds to earn investment income with the objective of maintaining safety of principal and providing adequate liquidity to meet cash flow requirements.

d) Market Risk

Market risk is the risk that changes in market prices, such as foreign exchange rates or interest rates, will affect the RHA's income or the value of its holdings of financial instruments. The objective of market risk management is to control market risk exposures within acceptable parameters while optimizing return on investment

i) Foreign Exchange Risk:

The RHA operates within Canada, but in the normal course of operations is party to transactions denominated in foreign currencies. Foreign exchange risk arises from transactions denominated in a currency other than the Canadian dollar, which is the functional currency of the RHA. The RHA believes that it is not subject to significant foreign exchange risk from its financial instruments.

13. Financial Instruments - continued

ii) Interest Rate Risk:

Interest rate risk is the risk that the fair value of future cash flows or a financial instrument will fluctuate because of changes in the market interest rates.

Financial assets and financial liabilities with variable interest rates expose the RHA to cash flow interest rate risk. The RHA's investments include long-term bonds bearing interest at coupon rates. The RHA's mortgages payable outstanding as at March 31, 2013 and 2012 have fixed interest rates.

Although management monitors exposure to interest rate fluctuations, it does not employ any interest rate management policies to counteract interest rate fluctuations.

As at March 31, 2013, had prevailing interest rates increased or decreased by 1%, assuming a parallel shift in the yield curve, with all other variables held constant, the RHA's financial instruments would have decreased or increased by approximately $46,000, approximately 4% of the fair value of investments.

e) Liquidity Risk

Liquidity risk is the risk that the RHA will not be able to meet its financial obligations as they become due.

The RHA manages liquidity risk by continually monitoring actual and forecasted cash flows from operations and anticipated investing and financing activities.

At March 31, 2013 the RHA has an operating cash balance of $8,372,228 (2012 - $8,943,267).

f) Fair Value

The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature:
- Cash and short-term investments
- Accounts receivable
- Accounts payable
- Accrued salaries and vacation payable

The fair value of mortgage payable and long term debt before the repayment required within one year is $7,225,829 (2012 $7,684,443) and is determined using discounted cash flow analysis based on current incremental borrowing rates for similar borrowing arrangements, net of mortgage subsidies.

13. Financial Instruments - continued

Fair value is best evidenced by an independent quoted market price for the same instrument in an active market. An active market is one where quoted prices are readily available, representing regularly occurring transactions. Accordingly, the determination of fair value requires judgment and is based on market information where available and appropriate. Fairr value measurements are categorized into levels within a fair value hierarchy based on the nature of the inputs used in the valuation.

Level 1 – Where quoted prices are readily available from an active market
Level 2 – Valuation model not using quoted prices, but still using a predominantly observable market inputs, such as market interest rates.
Level 3 – Where valuation is based on unobservable inputs. There were no items measured at fair value using level 3 in 2012 or 2013

There were no items transferred between levels in 2012 or 2013.

g) Short-term Borrowing/Operating Line-of-credit

The RHA has a line-of-credit of $1,000,000 (2012 - $1,000,000) with a floating rate of interest charged at Prime minus .50% which is re-negotiated annually. The line-of-credit is secured by accounts receivable including all grants, revenues and any other forms or sources of payments from the Province of Saskatchewan and any other funding bodies. Total interest paid on the line-of-credit in 2012 was $0 (2012 - $0).

14. Community Generated Funds

Under the terms of the pre-amalgamation agreement, the RHA has agreed to hold community generated assets in trust. The Board established a separate fund for the assets of each trust. Health corporations formerly held these assets before amalgamating with the Board. The assets are interest bearing with the interest credited to the trust balance. The Authority presently administers $4,092,946 (2012 - $3,293,456) under these agreements.

During the year, the RHA received and transferred to community generated funds and registered foundations trust monies of $0 (2012 - $0). Following is the status of the trust funds at March 31, 2013:

Each trust fund has a "Trust Advisory Committee" which is appointed by the various towns, villages, hamlets, and rural municipalities served by the pre-amalgamation agency. The trust funds are for the benefit of the ratepayers of the various municipalities and shall be used for health related purposes. The committees have the power to establish rules and procedures and the majority decision of the committees shall be binding upon the RHA with respect to any use of the trust fund.

15. Energy Performance Contract

Energy performance contracting is a unique program that allows the RHA to implement facility improvements, reduces energy costs, improve health and comfort conditions while contributing to the province's environmental objectives. *SaskPower Energy Solutions* performed extensive research to establish a baseline of annual cost savings they guarantee as part of this project. The project is expected to provide utility cost savings that will pay for the cost and financing of this project within an established time frame. Any additional savings are calculated and verified by methods established in the contract and are applied to the loan. Kelsey Trail Regional Health Authority entered into a guaranteed energy performance savings contract with *SaskPower Energy Solutions Company*.

The total cost of the energy performance contract is $4,861,669. As at March 31, 2013, construction costs of $4,785,198 (2012 - $4,785,198) have been financed through a $4,861,669 long-term debt loan with a balance of $4,283,110 outstanding (2012 - $4,463,456), which bears interest at a rate of 5.33%. The long-term debt is amortized over a period of 18.5 years.

Results of the energy renewal project since its inception are:

	2013	Prior Years	Total
Estimated Utility Savings	423,671	462,394	886,065
Interest Costs	233,539	602,009	835,548

16. Collective Agreements

The SGEU contract was in effect until March 31, 2012. The HSAS and SUN contracts are in effect until March 31, 2013 and March 31, 2014, respectively.

17. Pay for Performance

Effective April 1st, 2011, a pay performance compensation plan was introduced. Amounts over 90% of base salary are considered 'lump sum performance adjustments'. Senior employees are eligible to earn lump sum performance adjustments up to 110% of their base salary. During the year, senior employees are paid 90% of current year base salary and lump sum performance adjustments related to the previous fiscal year. At March 31, 2013 lump sum performance adjustments relating to 2012-13 have not been determined as information required to assess senior employee performance is not yet available.

18. Transition to Public Sector Accounting Standards

Adoption of public sector accounting framework

As stated in Note 2, these are the RHA's first financial statements prepared in accordance with Canadian public sector accounting standards. The accounting policies set out in Note 2 have been applied consistently in preparing the financial statements for the year ended March 31, 2013, the comparative information presented in these financial statements and the opening statement of financial position as at April 1, 2011 (the RHAs date of transition to public sector accounting standards).

18. Transition to Public Sector Accounting Standards (con't)

a) Financial Instruments

Effective April 1, 2012, the RHA adopted the PSA standards for *Financial Instruments* (PSA Handbook Section PS 3450). Section PS 3450 establishes standards on how to account for and report all types of financial instruments, including derivatives. Section PS 3450 has been applied prospectively, in accordance with the transitional provisions of the Section.

Upon adoption of Section PS 3450 the RHA was required to assign its financial instruments to one of two measurement categories: fair value; or cost or amortized cost. The RHA's financial assets and financial liabilities are measured at cost or amortized cost. Carrying amounts are in each instance disclosed in the Statement of Financial Position.

The adoption of Section PS 3450 had no impact on the recognition and measurement of financial instruments reported in these financial statements. There were additional items related to presentation and disclosure of financial instruments that have been added to Note 13 as a result of the adoption of this standard.

b) Employee Future Benefits

The RHA made an adjustment to the 2011 and 2012 financial statements with respect to the accounting for employee future benefits. Specifically, this adjustment related to accounting policy differences under public sector accounting standards with respect to the determination of the obligation for accumulated sick leave.

In aggregate, the resulting increase to the liability for employee future benefits at April 1, 2011 was $4,244,700. Employee future benefit expense for the year ended March 31, 2012 decreased by $57,000.

The impact of these restatements on the comparative figures is as below:

Summary of adjustments

Fund Balances:

The following table summarizes the impact of the transition to PSA standards on the RHA's operating fund balances as of April 1, 2011:

18. Transition to Public Sector Accounting Standards (con't)

Fund balances as at April 1, 2011:		
Fund balances, as previously reported	$	(602,260)
Adjustment to employee future benefits liability		(4,244,700)
Fund balances, as currently reported	$	(4,846,960)

Fund balances as at March 31, 2012:		
Fund balances, as previously reported	$	(1,547,384)
Adjustment to employee future benefits liability		(4,187,700)
Fund balances, as currently reported	$	(5,735,084)

Excess (Deficiency) of Revenues over Expenses:

As a result of the retrospective application of PSA standards, the RHA recorded the following adjustment to excess (deficiency) of operating fund revenues over expenses for the year ended March 31, 2012:

Excess (deficiency) of revenues over expenses for the year ended March 31, 2012:		
Excess (deficiency) of revenues over expenses, as previously reported	$	1,340,420
Adjustment to employee future benefits expense		57,000
Excess (deficiency) of revenues over expenses, as currently reported	$	1,397,420

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENSES BY OBJECT
For the Year Ended March 31, 2013

Schedule 1

	Budget 2013	Actual 2013	Actual 2012
Operating:			(Note 18)
Advertising & public relations	$ 91,608	$ 106,360	$ 90,336
Board costs	103,135	123,949	114,732
Compensation - benefits	14,490,774	14,506,462	14,393,440
Compensation - employee future benefits	-	(38,600)	(57,000)
Compensation - salaries	72,330,174	73,271,241	72,181,388
Continuing education fees & materials	226,235	207,784	208,195
Contracted-out services - Other	271,776	326,214	307,420
Diagnostic imaging supplies	28,600	14,931	12,172
Dietary supplies	99,909	127,092	116,543
Drugs	650,888	591,615	660,160
Food	1,694,657	1,671,398	1,638,530
Grants to ambulance services	2,790,581	2,790,582	2,764,038
Grants to health care organizations & affiliates	759,140	669,450	673,835
Housekeeping & laundry supplies	291,145	290,684	281,227
Information technology contracts	909,850	831,395	756,271
Insurance	247,900	215,893	243,788
Interest	241,615	239,702	251,555
Laboratory supplies	1,178,999	1,063,055	1,128,880
Medical & surgical supplies	2,573,435	2,386,078	2,342,153
Medical remuneration & benefits	10,095,167	10,159,084	8,407,039
Meetings	117,909	88,485	83,868
Office supplies & other office costs	435,339	399,701	417,594
Other	360,156	311,469	257,340
Professional fees	810,473	813,482	833,612
Prosthetics	-	-	-
Purchased salaries	833,098	520,337	493,139
Rent/lease/purchase costs	1,159,323	1,250,386	1,324,933
Repairs & maintenance	1,531,819	1,554,679	1,634,057
Supplies - Other	345,983	363,488	366,190
Therapeutic supplies	-	-	-
Travel	1,056,645	1,126,237	1,099,977
Utilities	2,240,560	2,409,507	2,275,822
Total Operating Expenses	$ 117,966,893	$ 118,392,140	$ 115,301,234
Restricted:			
Amortization		$ 4,088,098	$ 3,927,322
Loss/(Gain) on disposal of fixed assets		(3,700)	57,879
Mortgage Interest Expense		277,456	441,211
Other		77,286	36,642
		$ 4,439,140	$ 4,463,054

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF CONSOLIDATED INVESTMENTS
As at March 31, 2013

Schedule 2

	Fair Value	Maturity	Effective Rate	Coupon Rate
Restricted Investments*				
Cash and Short Term				
Chequing and Savings:				
Cornerstone Credit Union - Tisdale	$ 8,932,194			
Diamond North Credit Union	39,042			
	$ 8,971,236			
Term Deposits:				
	-			
	$ -			
Total Cash & Short Term Investments	$ 8,971,236			
Long Term				
	-			
Total Long Term Investments	$ -			
Total Restricted Investments	**$ 8,971,236**			
Unrestricted Investments				
Cash and Short Term				
Cash on Hand	$ 7,097			
Cornerstone Credit Union - Tisdale	7,852,090			
Advantage Credit Union	9,423			
Diamond North Credit Union	492,246			
Hudson Bay Credit Union	1,155			
Porcupine Credit Union	2,599			
Kelvington Credit Union	7,311			
Cornerstone Credit Union - Short Term	307			
Total Cash & Short Term Investments	$ 8,372,228			
Long Term				
Bonds	$ 1,221,325	Various	Variable	
Total Long Term Investments	$ 1,221,325			
Total Unrestricted Investments	**$ 9,593,554**			
Total Investments	**$ 18,564,790**			
Restricted & Unrestricted Totals				
Total Cash & Short Term	$ 17,343,463			
Total Long Term	1,221,325			
Total Investments	**$ 18,564,789**			

* Restricted Investments consist of:

- Community generated funds transferred to the RHA and held in the Community Trust Fund (Schedule 3); and
- Replacement reserves maintained under mortgage agreements with Canada Mortgage and Housing Corporation (CMHC) and or Saskatchewan Housing Corporation (an agency of the Department of Community Resources and Employment) (SHC) held in the Capital Fund (Schedule 4).

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2013

Schedule 3

COMMUNITY TRUST FUND EQUITY

Trust Name	Balance Beginning of Year	Investment & Other Revenue	Donation	Expenses / Transfers	Capital Expenses	Balance End of Year
Edith Campbell Bursary	$ 20,489	$ 309	$ 2,500	$ -	$ -	$ 23,298
Hudson Bay Health Care Facility	191,800	2,742	27,650	(2,145)	-	220,046
Kelvindell Lodge	134,457	1,739	7,455	(16,629)	-	127,022
Kelvington Hospital	133,907	1,902	8,688	(1,841)	(8,128)	134,529
New Market Place	381,951	7,977	405,570	335,129	(85,032)	1,045,594
Pam Worley Bursary	789	11	-	-	-	800
Community Services	124,709	1,739	300	-	(11,147)	115,602
Porcupine Plain Hospital	232,989	3,248	9,976	(907)	(9,121)	236,185
Ralston Medical Research	564,419	7,942	494	-	-	572,855
Red Deer Nursing Home	55,356	851	19,820	-	(18,037)	57,991
Rose Valley Health Centre	81,737	1,146		(500)	-	82,383
Sasko Park Lodge	157,050	2,855	5,974	(165,879)	-	(0)
Tisdale Hospital	1,138,558	19,073	441,002	(198,250)	(16,014)	1,384,368
Tisdale Hospital - Dialysis Unit	75,244	1,151	15,877	-	-	92,273
Total Community Trust Fund	**$ 3,293,456**	**$ 52,684**	**$ 945,306**	**$ (51,021)**	**$ (147,479)**	**$ 4,092,946**

CAPITAL FUND

	Balance Beginning of Year	Investment & Other Income	Capital Grant Funding	Expenses	Capital Expenses	Balance End of Year
Cumberland House Project	$ 107,344	$ -	$ -	$ -	$ (50,150)	$ 57,194
Energy Performance Contract	76,471	-	-	-	-	76,471
Ministry of Health - Block Funding	765,883	-	215,000	-	(646,825)	334,057
Ministry of Health - Capital Equipment	299,250	-	170,000	-	(196,223)	273,027
Ministry of Health - Capital Projects	4,312,876	1,715,138	4,000,000	-	(7,334,525)	2,693,489
Ministry of Health - CT Project	435,500	-	-	-	(6,100)	429,400
Ministry of Health - Radiology Equipment	962,238	-	-	-	(166,185)	796,053
Ministry of Health - Safety and Surgical	507,345	-	191,000	-	(309,298)	389,047
Other	125,997	69,615	-	-	(86,174)	109,438
Total Capital Fund	**$ 7,592,902**	**$ 1,784,754**	**$ 4,576,000**	**$ -**	**$ (8,795,480)**	**$ 5,158,176**
TOTAL EXTERNALLY RESTRICTED FUNDS	**$ 10,886,359**	**$ 1,837,438**	**$ 5,521,306**	**$ (51,021)**	**$ (8,942,959)**	**$ 9,251,122**

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY RESTRICTED FUND BALANCES
For the Year Ended March 31, 2013

Schedule 4

	Balance, beginning of year	Investment income allocated	Annual allocation from unrestricted fund	Transfer to unrestricted fund (expenses)	Capital Expenses	**Balance, end of year**
Capital						
SHC Replacement Reserves						
Arborfield Special Care Home	$ 130,578	$ 1,854	$ -	$ -	$ -	$ 132,432
Chateau Providence	167,303	992	7,750	-	(123,669)	52,376
Hudson Bay Health Care Facility	47,982	658	5,080	-	(4,000)	49,720
Kelvindell Lodge	71,631	1,017	8,043	-	-	80,691
Newmarket Manor	200,637	2,791	-	-	(5,471)	197,957
Nirvana Pioneer Villa	44,579	633	12,000	-	-	57,212
Pasquia Special Care Home	48,583	3,479	5,800	-	(6,567)	51,295
Pineview Lodge	9,385	57	11,254	-	(15,951)	4,745
Red Deer Nursing Home	52,512	746	-	-	-	53,258
Sasko Park Lodge	3,236	46	4,320	-	-	7,602
Total SHC	$ 776,427	$ 12,273	$ 54,247	$ -	$ (155,659)	$ 687,289
Other Internally Restricted Funds						
Activities - Arborfield Special Care Home	6,786	11,494	-	(7,032)	-	11,248
Activities - Carrot River	22,646	20,133	-	(19,232)	-	23,546
Ambulances	63,687	755	50,000	-	(12,827)	101,616
Capital	22,690	727,780	375,000	-	(438,544)	686,926
Cumberland House Home Care	21,859	307	-	-	-	22,167
Cumberland House Health Centre	17,524	249	7,500	-	-	25,273
Newmarket Manor - Floor Account	247,430	3,479	-	-	-	250,910
Palliative Home Care	4,194	53	-	-	-	4,247
Parkland	209,709	2,773	20,000	-	(24,998)	207,483
Rose Valley Health Centre	48,703	9,777	8,111	-	-	66,591
Tisdale Joint Use Facility	4,874	68	290	-	-	5,233
Total Capital	**$ 1,446,531**	**$ 789,142**	**$ 515,148**	**$ (26,265)**	**$ (632,027)**	**$ 2,092,529**
Operating						
Other Internally Restricted Funds						
	$ -	$ -	$ -	$ -	$ -	$ -
Total Operating	$ -	$ -	$ -	$ -	$ -	$ -
Total Internally Restricted Funds	**$ 1,446,531**	**$ 789,142**	**$ 515,148**	**$ (26,265)**	**$ (632,027)**	**$ 2,092,529**

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULES OF
BOARD MEMBER REMUNERATION
for the year ended March 31, 2013

Schedule 5(a)

RHA MEMBERS	RETAINER	PER DIEM	TRAVEL TIME EXPENSES	TRAVEL AND SUSTENANCE EXPENSES	OTHER EXPENSES	CPP	2013 TOTAL	2012 TOTAL
Chairperson								
Wilfred Veller[1]	830	881	534	-	-	-	2,245	32,901
Rennie Harper[2]	9,130	13,678	6,756	-	-	130	29,694	-
Board Member								
Rennie Harper[6]	-	8,014	2,374	-	-	45	10,433	14,721
Clarence Hendrickson	-	8,638	5,261	-	-	-	13,899	11,920
Rose Morin[4]	-	-	-	-	-	-	-	1,889
Darrell Guy	-	5,425	3,905	-	-	-	9,330	14,427
Kathleen Bedard	-	8,133	5,152	-	-	364	13,649	-
Carla Hipkins[4]	-	1,263	573	-	-	36	1,872	4,145
Gordon Cresswell	-	6,031	3,325	-	-	122	9,478	5,017
Dennis Koch	-	5,338	1,765	-	-	151	7,254	8,866
Allyson Stevenson[4]	-	238	52	-	-	5	295	6,368
Frank Garchinski	-	5,527	3,388	-	-	-	8,915	5,632
Cheryl Watt[7]	-	263	96	-	-	6	365	9,717
Rhonda Desjarlais[3,5]	-	550	358	-	-	21	929	-
Richard Radom[3]	-	5,638	2,863	-	-	232	8,733	-
Nancy Steinbachs[3]	-	5,688	3,696	-	-	217	9,601	-
Vacant Position	-	-	-	-	-	-	-	-
TOTAL	**9,960**	**75,305**	**40,098**	-	-	**1,329**	**126,692**	**115,603**

[1] Resigned April 23, 2012

[2] Term began April 23, 2012

[3] Term began September 4, 2012

[4] Term ended May 22, 2012

5Resigned December 31, 2012

[6] Term ended April 23, 2012

[7] Term ended April 1, 2012

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES, AND SEVERANCE

for the year ended March 31, 2013

Schedule 5 (b)

	2013							2012		
Senior Employees	**Salaries**[1]	**Vacation Payout**[1]	**Sub-total** (Total Salaries)	**Benefits and Allowances**[2]	**Sub-total**	**Severance Amount**	**Total**	**Salaries, Benefits & Allowances**[1,2]	**Severance**	**Total**
Glen Kozak, CEO	$ 261,285	$ -	$ 261,285	$ 3,163	$ 264,448	$ -	264,448	$ 231,687	$ -	$ 231,687
Senior Positions:										
Pam McKay VP Institutional & Emergency Care	221,390	34,951	256,341	66	$ 256,407	-	256,407	190,205	-	190,205
Shane Merriman VP Finance & Information Services	222,455	-	222,455	66	$ 222,521	-	222,521	189,282	-	189,282
Julie Cleaveley[3] VP Community & Primary Health Care	16,375	49,123	65,498	8	$ 65,506	-	65,506	171,021	-	171,021
Richard Peters[4] VP Community & Primary Health Care	113,295	7,524	120,819	58	$ 120,877	-	120,877	-	-	-
Dr. Wingate VP Medcial Services & Chief of Staff	150,342	-	150,342	3,600	$ 153,942	-	153,942	139,565		139,565
Total	**$ 985,142**	**$ 91,598**	**$ 1,076,740**	**$ 6,961**	**$ 1,083,701**	**$ -**	**$ 1,083,701**	**$ 921,760**	**$ -**	**$ 921,760**

1. Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave, and merit or performance pay, lumpsum payments, and any other direct cash remuneration. Senior employee salaries were paid 90% of base salary. Senior employees are eligible to earn up to 110% of their base salary. Performance adjustments have not been determined for the year ended March 31, 2013 and will be paid out in the 2013-14 fiscal year. This schedule will be amended in the 2013-14 fiscal year to reflect the performance adjustments. Refer to Note 17 for further details.

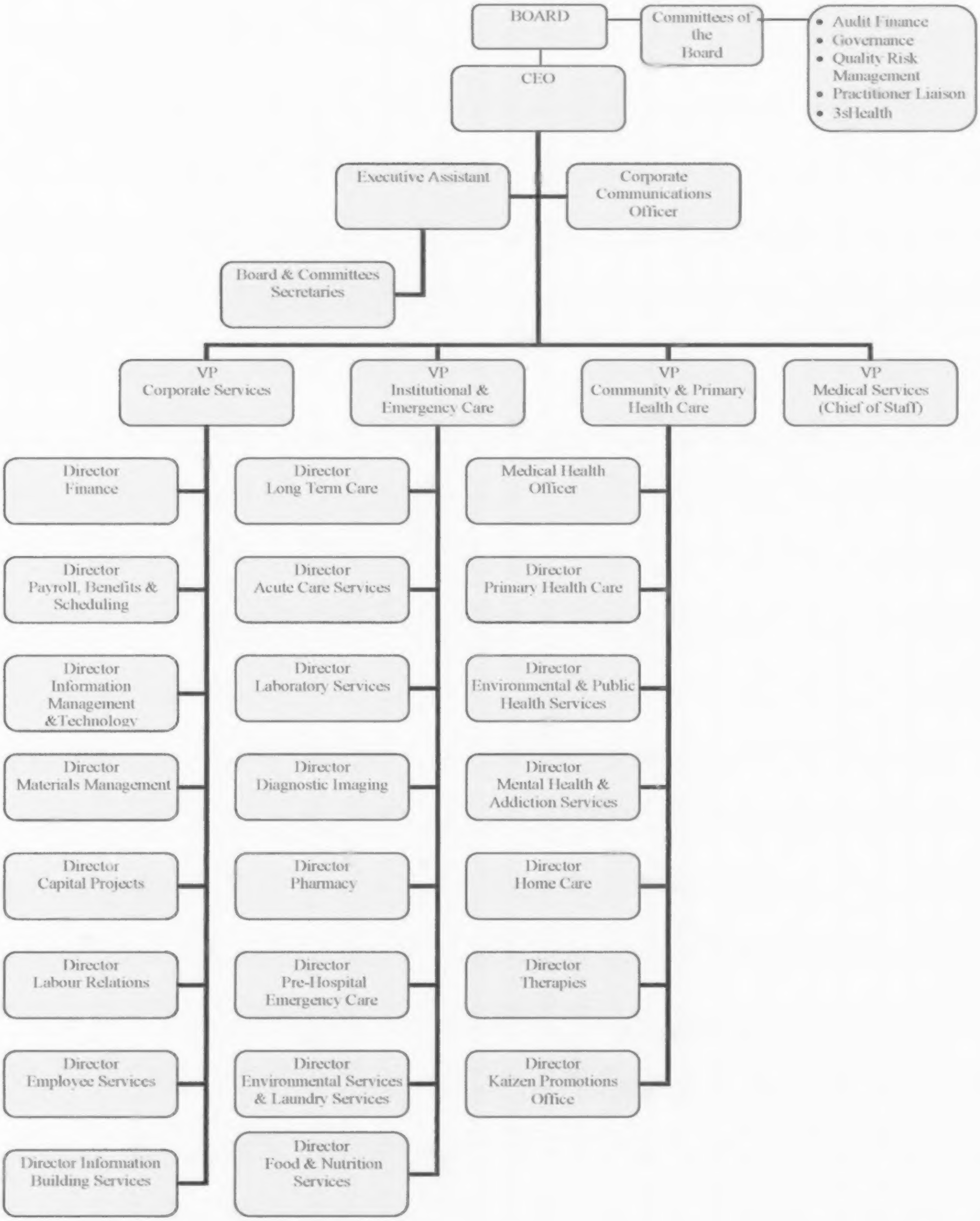
2. Benefits and Allowances include the employer's share of amounts paid for the employees' benefits and allowances that are taxable to the employee. This includes taxable: professional development, education for personal interest, non-accountable relocation benefits, personal use of: an automobile; cell-phone; computer; etc. As well as any other taxable benefits.

3. Resigned May 9, 2012

4. Interim position May 14, 2012

Appendices

2012-13 Organizational Chart


BOARD
Committees of the Board
Audit Finance
Governance
Quality Risk Management
Practitioner Liaison
3sHealth
CEO
Executive Assistant
Corporate Communications Officer
Board & Committees Secretaries
VP Corporate Services
VP Institutional & Emergency Care
VP Community & Primary Health Care
VP Medical Services (Chief of Staff)
Director Finance
Director Payroll, Benefits & Scheduling
Director Information Management &Technology
Director Materials Management
Director Capital Projects
Director Labour Relations
Director Employee Services
Director Information Building Services
Director Long Term Care
Director Acute Care Services
Director Laboratory Services
Director Diagnostic Imaging
Director Pharmacy
Director Pre-Hospital Emergency Care
Director Environmental Services & Laundry Services
Director Food & Nutrition Services
Medical Health Officer
Director Primary Health Care
Director Environmental & Public Health Services
Director Mental Health & Addiction Services
Director Home Care
Director Therapies
Director Kaizen Promotions Office

KELSEY TRAIL
HEALTH REGION

VISION

Healthy people in healthy communities

MISSION

Working together to improve the health of people

VALUES

Respect

We will support our clients, colleagues & partners in positive, productive relationships.

Transparency

We see every interaction as an opportunity for caring, compassion & to build trust with each person.

Excellence

We will pursue excellence through diligent effort, both individually and collectively.

Accountability

We are thoughtful guardians of our resources.

Engagement

We will continually work to earn confidence, faith and collaboration with our clients & colleagues.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY

PAYEE DISCLOSURE LIST
For the Year Ended March 31, 2013

As part of government's commitment to accountability and transparency, the Ministry of Health and Regional Health Authorities disclose payments of $50,000 or greater made to individuals, affiliates and other organizations during the fiscal year. These payments include salaries, contracts, transfers, supply and service purchases and other expenditures.

Personal Services

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more

Aasen, Corey	$ 55,650.00	Beecher, Clint	$ 56,419.16
Aasen, Tammy	82,974.52	Bergren, Dorothy	101,368.88
Adames, Oralee	88,947.66	Bertrand, Marilyn	70,121.73
Anderson, Barbara	92,266.21	Bigelow, Sharyl	60,443.75
Anderson, Christie	103,219.56	Bischoff, Carrie	123,114.02
Anderson, Penny	116,122.21	Bittman, Lyle	104,880.51
Andrus, Angela	90,368.13	Bitzer, Denise	110,371.94
Arneson, Anna	88,580.70	Black, Joan	101,771.98
Assie, Ramona	118,553.44	Bohaychuk, Vickie	61,657.51
Astrope, Trudy	88,973.72	Bohmann, Peggy	57,687.81
Atkings, Deborah	91,098.40	Bolduc, Jennifer	68,717.12
Atkinson, Lorette	74,525.08	Bonsan, Roxane	77,893.93
Bagnall, Charlott	98,249.65	Borsa, Shannon	64,701.08
Ballendine, Laurie	60,492.10	Boughen, Janice	80,341.22
Baptist, Farrah	61,834.75	Bouvier, Gisele	95,875.69
Baranieski, Cay	51,935.57	Boxall, Lia	147,679.61
Barlow, Linda	122,323.61	Braaten, Lynda	72,457.29
Barrie, Amber	61,536.37	Bradley, Margaret	89,884.08
Bartel, Heather	60,596.87	Bradshaw, Katherine	98,130.22
Bashforth, Crystal	59,793.51	Brakstad, Terry	72,955.88
Bayne, Bonny	51,509.22	Brockman, Judy	116,827.80
Beaulieu, Sharon	73,384.63	Brothwell, Linda	110,604.44
Becker, Kaye	108,145.19	Brothwell, Sherry	66,317.63
Bedard, Tracy	94,757.95	Brown, Diane	76,299.50
Bednarz, Amanda	72,065.75	Brown, Tammy	60,280.30
Bednarz, Chelsey	72,226.08	Bruce, Lindsey	53,592.05

Bryson, Dennis	$ 73,085.09	De Haan, Sonya	$ 82,919.33
Buhler, Jessie	73,235.05	Dean, Melody	101,056.52
Burghardt, Shelley	59,481.78	Delwisch, Sandra	69,740.15
Burt, Mary	87,447.51	DeMarsh, Terry	82,080.65
Burton, Violet	92,181.95	Derenowski, Carmen	50,785.18
Buyaki, Peggy	62,429.32	Dierker, Christine	93,310.85
Cal, Shelly	167,740.77	Diller, Ronald	104,563.88
Campbell, Quentin	51,238.87	Dobrinski, Barb	101,302.91
Campbell, Vivian	118,137.11	Dobson, Tina	102,949.66
Carlson, Sandra	88,307.16	Donald, Ronda	111,601.08
Carswell, Kathryn	79,281.44	Doucette, Natalie	112,389.25
Chabot, Catherine	82,476.76	Douslin, Sharon	76,969.60
Chaboyer, Sheila	71,008.12	Drake, Chantelle	73,306.40
Chapman, Jeannine	93,643.07	Draude, Pattie	90,013.45
Charko, Jessie	69,990.86	Drotar, Lynnette	69,098.12
Chorney, Jessica	73,912.01	Duerksen, Loretta	81,649.96
Christianson, Leslie	72,969.70	Dyck, Christine	139,315.32
Chrusch, Garry	75,388.17	Dyck, Stephanie	70,308.20
Chrusch, Maureen	95,922.98	Edstrom, Darlene	83,819.87
Chute Bodvarson, Bobbi	67,073.63	Edwards, Shelly	92,627.11
Clarke, Janice	92,841.79	Enge, Terry	68,010.30
Clarke, Leeann	81,851.11	Ens, Cheryl	65,451.30
Claypool, Renee	72,414.22	Ens, Evan	82,080.65
Cleaveley, Julie	65,497.84	Erickson, Bonnie	50,205.44
Cleaveley, Maria	112,764.07	Ericson, Rayleen	50,560.61
Code, Jacquelin	67,952.32	Ernst, Raeann	79,855.52
Coleman, Elise	81,998.80	Espenant, Rodney	99,306.07
Collins, Beverly	51,851.16	Ewen, Linda	64,788.34
Connor, Anne	72,013.66	Ewen, Sandy	76,198.13
Crickett, Donna	97,344.34	Fagnou, BettyLou	92,587.09
Currie, Debra	65,840.95	Fannon, Lee Ann	85,288.78
Curry, Meghan	55,617.57	Farber, Tracy	111,871.52
Cyr, Ron	71,761.48	Fawcett, Jeffrey	62,090.84
Dagg, Arlene	59,863.35	Fawcett Parkman, Carol	66,436.92
Dagg, Leslie	94,563.06	Fellman, Leanne	90,891.15
Dahl, Sherry	99,334.96	Ferguson, Heather	101,442.74
Daisley, Rosalie	59,847.50	Ferre, Arien	62,005.93
Dalziel, Joan	99,075.07	Fesalbon, Rosal	66,223.76
Daoust, Roxane	83,516.46	Fidyk, Melanie	101,448.97
Davis, Andrea	54,695.47	Fielder, Jessica	82,615.41
Day, Karen	102,967.84	Firman Depeel, Christine	98,992.75

Flamand, Sonia	$ 61,207.82	Hanaback, Kimberly	$ 51,204.96
Folden, Deanna	84,751.32	Hancock, Jason	74,002.41
Fortin, Wendy	60,227.33	Hancock, Tracie	62,018.28
Foster, MaryAnne	80,493.50	Harbicht, Faye	73,286.74
Fountain, Kyla	68,055.58	Hart, Sandra	56,852.06
Francais, Maureen	61,591.49	Haugo, Aline	72,365.87
Franke, Vera	74,930.96	Hayduk, Michael	79,693.15
Franklin, Judy	70,549.86	Hayes, Wendy	78,405.74
Franklin, Karri	101,442.71	Hayward Hunkin, Mickie	76,193.15
Freedman, Allison	59,180.84	Hayworth, Beverly	72,182.09
Friesen, Dwayne	74,999.45	Heatherington, Breann	59,422.20
Frisky, Sharon	114,888.25	Hebert, Caitlin	66,749.07
Fullerton, Natasha	73,985.22	Hedin, Cody	67,439.89
Funk, Rebecca	61,418.92	Hemingson, Linda	99,433.58
Gagnon, Terrah	72,342.91	Henderson, Elaine	96,410.57
Gallays, Paulette	97,824.65	Herbert, Chelsea	88,565.77
Gallays, Robynn	66,090.08	Hermus, Joan	88,874.70
Galucan, Carolyn	104,043.21	Heron, Maureen	66,485.73
Ganton, Sonia	60,000.12	Heron, Renee	63,626.65
Garchinski, Kimberley	87,014.46	Hewitt, Anna Dawn	94,418.84
Garland, Stephanie	95,359.90	Hiebert, Kari	98,751.86
Genik, Heather	103,632.08	Hilkewich, Jocelyn	97,106.54
George, Myrna	60,166.63	Hirsch, Jana	90,375.86
George-Fairbairn, Jeanne	60,367.22	Hobbins, Tim	104,880.49
Gessner, Mary	69,382.09	Hoffus, Diane	75,621.58
Getachew, Eyoueal	68,822.85	Hoffus, Kelly	69,455.09
Glaves, Connie	118,137.11	Hoffus, Marianna	96,406.88
Glister, Sherrie	63,945.80	Honoway, Sean	92,626.40
Gooliaff, Dolores	81,206.24	Hooge, Melissa	82,178.72
Gordon, Ardis	68,113.69	Hoyt, Catherine	54,131.81
Gray, Raymond	51,605.00	Hrenkiw, Collette	52,036.14
Gray, Shawna	82,146.53	Hrychuk, Michelle	75,518.70
Grona, Daniel	106,243.41	Hudak, Darlene	60,796.31
Gudnason, Douglas	98,799.15	Hughes, Tracy	89,568.45
Hage, Barbara	76,917.90	Hunt, Shirley	91,098.90
Hagen, Maureen	91,300.00	Hunt, Stacey	85,300.10
Hainstock, Donna	65,459.80	Isberg, Kathie	51,595.21
Hall, Judy	50,146.46	Ives, Brenda	74,781.20
Hall, Michelle	66,256.44	Jackson, Vanessa	62,828.27
Halvorsen, Elaine	101,235.63	Jamieson, Joan	73,384.67
Hampton, Bonnie	102,508.86	Janzen, Crystal	77,356.11

Jeffrey, Audrey	$ 69,928.75	Lindal, Karen	$ 75,314.33
Johnson, Bonnie	92,422.83	Lindsay, Lynda	88,706.07
Johnson, Marilyn	50,038.53	Lindsay, Maureen	65,735.28
Jones, Judy	72,049.00	Lipka, Sharon	50,627.69
Kehrig, Beverly	81,409.61	Little, David	82,080.65
Khan, Mohammad	222,931.67	Litzenberger, Joan	94,770.80
Kiefer, Marilyn	121,079.60	Logan, Kim	104,007.64
Kimball, Valerie	100,644.34	Love, Nicolette	92,460.45
Kinch, Derek	54,625.15	Lueken, Linda	104,220.02
Kirk, Wendy	64,534.21	Lukaszuk, Lucy	54,458.82
Kirkland, Sherrie	55,637.86	Lundy, Jody	64,682.50
Kiteley, Wanda	65,629.18	Lungull, Ervin	72,807.87
Kjelshus, Leslie	58,603.82	Lyons, Barry	58,213.48
Klassen, Linda	70,473.01	Mackie, Carmen	95,859.40
Kleiboer, Sharon	73,292.02	Mahon, Sherry	85,984.67
Knudsen, Irene	74,663.83	Mahussier, Wanda	86,584.16
Knudtson, Shirley	69,023.32	Major, Lisa	125,437.01
Kolodinsky, Charleen	56,205.77	Malhi, Sukhwinde	50,398.34
Kolybaba, Amanda	59,016.13	Mamer, Francoise	108,422.08
Koroll, Jarod	72,028.52	Mansiere, Shaye	67,755.31
Kovach, Tammy	105,734.34	Marchildon, Marianne	71,107.91
Kovacs, Coral	87,441.63	Marshak, Audrey	57,597.70
Kowal, Joell	62,503.96	Martens, Heather	54,190.39
Kowal, Louise	93,471.57	Martens, Lesley	79,053.79
Kozak, Glen	261,285.32	Martin, Kade	74,404.20
Kuhberg, Sylvia	59,715.17	Martin, Pauline	102,307.64
Kuras, Crystal	67,711.38	Matiasz, Tammy	83,797.65
Kwasney, Laurie	104,958.25	McCleary, Angela	70,079.02
Lacheur, Debra	56,205.77	McCorriston, Elizabeth	71,853.44
Lalonde, Deborah	71,673.06	McCreadie, Stacey	89,219.16
Lalonde, Florence	55,790.35	McFarlane, Lana	70,368.53
Lamont, Audrey	68,430.17	McKay, Pamela	256,341.07
Larsen, Angela	61,483.21	McKee, Kara	54,357.06
Le Bras, Doreen	70,695.84	McLaren, Terri	81,055.86
Le Grand, Mildred	56,190.83	McLean, Cheryl	97,622.82
Lechler, Pamela	56,931.96	McShannock, Nancy	52,228.85
Lee, Roxanne	97,486.41	McWillie, Greg	103,460.29
Leek, Brenda	70,652.16	Meier, Bonnie	86,236.87
Leepart, Beverly	58,151.07	Melrose, Beverly	68,191.76
Lepine, Crystal	54,640.58	Menzies, Annette	59,350.11
Letendre, Dennis	50,465.98	Merriman, Shane	222,455.34

Messner, Janice	$ 110,092.43
Mevel Degerness, Nadine	109,072.37
Meyer, Kathleen	103,230.97
Meyers, Candace	74,925.31
Meyers, Stacey	87,497.00
Michaliew, Alison	58,708.04
Miller, Heather	91,097.15
Miller, Margaret	97,250.36
Misselbrook, Janet	54,145.47
Misskey, Lisa	85,597.45
Mitchell, Trent	111,268.37
Molnar, Kevin	69,976.92
Molnar, Pamela	93,555.40
Moneta, Shari	73,486.29
Mooney, Marlys	64,931.84
Moore, Crystal	92,695.28
Moore, Nicolette	53,828.02
Morrow, Irene	70,590.59
Moulton, Tanya	97,732.20
Musselman, Leanne	67,516.31
Naber, Colleen	100,900.22
Nagano, Marlene	121,794.18
Nagy, Garnet	74,546.51
Nagy, Katelyn	63,431.67
Nagy, Stacey	68,530.20
Nakonieczny, Ada	51,047.92
Nanaquewetung, Lesley	66,067.38
Neigel, Cindy	83,097.38
Neigel, Sarah	78,935.45
Neiszner, Tanya	95,516.46
Nelson, Michele	67,725.49
Neu, Monica	69,708.88
Neufeld, Anjie	83,100.53
Nicholls, Joanne	60,048.10
Nickel, Rhonda	102,956.96
Nontell, Joann	95,277.95
Nontell, Margaret	63,945.82
Nordmarken, Kimberly	50,986.30
Nyirenda, Julien	104,042.61
O'Flanagan, Cheryl	69,744.29
Oftebro, Marilyn	77,582.57
Ollinger, Mark	$ 90,095.78
Ollinger, Monique	93,889.21
Olson, Dinah	93,906.49
Olson, Michelle	92,015.03
Olson, Patricia	111,110.95
Palaniuk, Carla	92,467.32
Parlee, Tammy	101,442.74
Patenaude, Elaine	69,234.03
Patenaude, Judy	71,137.10
Patterson, Dale	65,536.06
Patterson, Trudy	50,069.69
Pederson, Patricia	100,627.42
Penner, Andrea	50,627.84
Penner, Shelley	58,194.44
Perrault, Linda	99,262.99
Perrault, Roxanne	73,048.17
Peters, Richard	136,254.82
Peters, Sharon	101,442.65
Peterson, Linda	88,546.13
Peterson, Sheryn	73,090.95
Philipation, Ryan	93,223.16
Phillips, Angela	51,903.01
Pieterse, Sandra	115,061.53
Poggemiller, Sarah	66,633.74
Pohl, Christine	111,601.08
Pohl, Curtis	100,763.95
Pohl, Jennifer	67,326.72
Pratt, Laureen	67,276.71
Ralph, Diane	50,096.31
Ratcliffe, Peggy	82,078.60
Reed, Lorry	93,206.38
Reid, Barbara	81,584.85
Riemer, Christina	92,126.61
Roberts, Elizabeth	73,368.75
Robertson, Rita	81,702.69
Robin, Rosanne	124,250.11
Rogers, Candace	75,286.12
Romaniuk, Trina	74,866.88
Rudachyk, Betty	61,259.46
Rudy, Tara	59,661.37
Rudychuk, Margaret	101,102.34

Runn, Diane	$ 91,720.93	Spratt, Coralie	$ 60,160.91
Rutherford, Shelley	123,160.03	Stadnek, Sonja	92,940.53
Ryhorchuk, Mabel	88,936.81	Stensrud, Colleen	132,274.98
Sales, Josie	102,438.11	Stensrud, Kelsey	59,959.52
Samida, Lorie	69,483.30	Stevenson, Barbara	95,273.47
Sauer, Teresa	51,470.18	Stevenson, Cheryl	80,169.35
Scarf, Jeannette	98,971.60	Stevenson, Kathleen	95,409.12
Scheidl, Carol	108,938.56	Stewart, Geoff	72,325.12
Scheidl, Leonard	82,860.14	Stewart, Josi	64,927.18
Schell, Wendy	91,179.37	Street, Faye	92,374.64
Schidlowsky, Patti	94,673.55	Streeton, Patricia	93,090.00
Schlechte, Kristin	81,033.16	Strnad, Amanda	54,023.34
Schmaltz, Carlene	93,533.48	Stroeder, Kellie	78,564.22
Schmitt, Joyce	57,377.09	Stroeder, Kyle	76,698.76
Schryvers, Kendall	54,479.71	Stuart, Nikki	75,399.65
Schuler, Marijane	85,747.45	Styan, Cathy	63,945.80
Scott, Kaeli	56,151.01	Sullivan, Norinne	82,299.14
Scutchings, Jodie	74,373.59	Sundelin, Jacquelin	64,836.57
Sealey, Alisa	86,234.92	Swider, Darcy	51,204.97
Seck, Emily	56,876.63	Syrenne, Sharon	51,772.82
Seiferling, Sheila	110,883.48	Szucs, Denise	69,468.36
Senecal, Jean	74,584.53	Tatarynovich, Emily	56,914.69
Serhan, Debbie	67,933.88	Tatarynovich, Mary	103,275.30
Settee, Amy	67,379.92	Taylor, Etta	69,258.52
Shearer, Connie	77,654.23	Taylor, Tammy	50,861.23
Shreve, Lisa	70,514.66	Telawsky, Christine	83,500.35
Siddons, Sandra	56,205.75	Terry, Douglas	111,153.87
Simoneau, Renee	92,911.90	Thevenot, Karen	67,447.45
Simonson, Wendy	58,786.85	Thibodeau, Terry	63,371.75
Sisson, Maxine	50,113.88	Thiessen, Corey	62,134.66
Skilliter, Dianne	95,993.33	Thompson, Tammy	63,863.14
Slobodzian, Fred	91,097.17	Tosh, Lee	83,886.85
Slobodzian, Kacy Jae	64,731.77	Toy, Yong	52,095.16
Smears, Wanda	68,773.52	Trawin, Julie	57,542.93
Smith, Brooke	80,528.29	Trombley, Christine	63,245.66
Smith, Diane	86,389.07	Tung, Tony	71,568.68
Sochaski, Linda	51,298.85	Tyckon, Lorraine	88,198.86
Solsten, Julie	91,740.38	Uhryn, Chantel	73,668.78
Soonias, Myrna	56,887.91	Unger, Catherine	102,780.01
Sorestad, Tracy	60,660.82	Unruh, Debbie	70,159.82
Sprackman, Michelle	54,628.15	Unruh, Lindsay	83,291.77

Van Herk Auger, Rosemary	$ 67,410.81	Wesnoski, Barbara	$ 53,129.93
VanCamp, Jackie	114,609.05	White, Dale	116,985.32
Vandertweel, Barbara	82,352.90	Whitehead, Merna	71,669.15
Vandeveen, Gloria	74,845.08	Wiebe, Helen	91,098.89
Verklan, Louise	101,442.73	Wilson, Chantel	53,762.50
Voisey Doucette, Delvena	110,899.26	Wilson, Cheri	89,739.71
Walker, Cristen	73,181.12	Wilson, Doris	86,639.70
Wall, Christa	63,945.82	Witter, Kirsten	63,356.81
Wallington, Julia	55,974.74	Wood, Kelsi	53,165.40
Walter, Darin	112,271.66	Woodward, Michael	71,364.60
Warkentin, Ruth	54,338.55	Worsley, Rose Kathy	92,057.17
Warner, Bessie	106,156.68	Wozniak, Deborah	75,151.10
Warriner, Valerie	156,111.66	Yaholnitsky, Pearl	97,447.32
Wassill, Pamela	59,535.16	Yaremy, Carol	54,192.61
Watson, Jennifer	76,847.46	Yeo, Charles	83,975.14
Watt, Anita	101,442.73	Youzwa, Sandee	86,867.81
Wehrkamp, Mary Jane	51,204.98	Zens, Arlene	111,601.08
Weiman, Blair	93,125.34	Zenuk, Antonie	61,168.52
Weseen, Sandra	112,883.94	Zip, Leanne	54,769.88

Transfers

Listed, by program, are transfers to recipients who received $50,000 or more.

None

Supplier Payments

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts and equipment.

3sHealth	$ 3,813,963.57	Gurgul, Dr. Mariusz	144,000.00
Archerwill Local # 58	148,047.45	Hanekom, Dr. P.	58,535.96
Bala, Dr. Medical Prof. Corp	390,193.78	Health Science Assoc of Sask.	$ 67,366.53
City of Melfort	86,575.44	Honeywell Limited	282,290.32
CPDN/RCDP	201,226.43	Hudson Bay Medical Group	1,535,752.61
Crestline Coach Ltd	133,734.81	Kelvington Ambulance Care Ltd	419,495.28
eHealth Saskatchewan	204,256.32	Laosebikan, Dr. A	75,058.08
GE Healthcare IITS Canada Ltd	65,550.00	London Life Insurance Co.	100,078.00
Glaxo Smithkline Inc	55,125.13	McKesson Canada	188,303.13
Great West Life	459,476.03	Melfort Ambulance Services	503,431.13

Ministry of Central Services	599,331.96
Nipawin Flight Center	84,960.00
Nipawin Medical Group	168,580.00
Nipawin Oasis Community Centre Co-op Ltd.	56,751.73
North East EMS	$ 1,021,284.57
North Sask Laundry & Support Services	688,309.74
Parkland Ambulance Care Ltd.	112,690.96
Philips Healthcare	139,340.36
Prairie North Co-op	53,062.62
Public Employees Superannuation Plan	76,420.63
Rye, Dr. J. G.	114,770.77
Saputo Foods Limited	115,061.54
Sask Energy	1,145,083.01
Sask Housing	55,086.00
Sask Power	1,139,046.80
Sask Tel	767,396.66
Saskatchewan Government Employees Union	1,066,320.57
Saskatchewan Health Employee's Pension Plan	10,469,414.18
Saskatchewan Registered Nurses Association	120,360.00
Saskatchewan Union of Nurses	272,931.58
Saskatchewan Workers Compensation Board	1,925,766.18
Saskatoon Regional Health Authority	339,320.59
Shamrock Ambulance Care Ltd	$ 233,892.12
Siemens Building Technologies	91,534.05
Steffen, Dr. Robert	56,344.30
Strydom, Dr. Eben	77,647.74
Sun Life Financial	60,815.70
Supreme Basics	109,054.85
Sysco Food Services of Regina	1,184,139.76
Tisdale Ambulance Care Ltd	495,131.06
Town of Naicam	154,054.54
Town of Nipawin	69,942.37
Town of Tisdale	100,309.74
Van Der Merwe, Dr. Neville	335,793.77
Van Der Ross, Dr. Richard	100,612.01
Van Heerden, Dr. Hendrick	101,714.03
Van Heerden, Dr. M.M.	75,762.45
Van Houtte Coffee Services Inc	76,016.88
Wingate, Dr. Jordan	153,942.00

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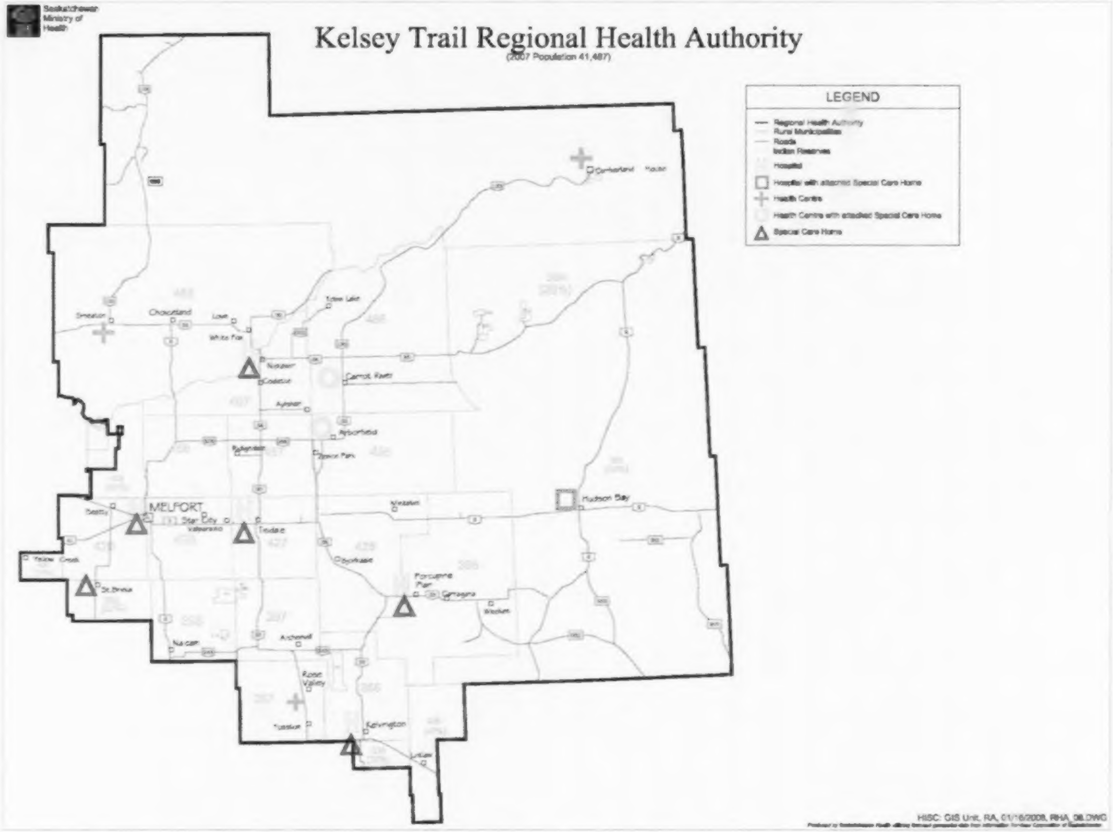
For More Information

For further information relevant to the Kelsey Trail Health Region, contact Regional Office at (306)873-6600 or visit the following websites:

Northeast Regional Intersectoral Committee
http://www.northeastric.ca/

Kelsey Trail Health Region
http://ww.kelseytrailhealth.ca/


Saskatchewan Ministry of Health
Kelsey Trail Regional Health Authority
(2007 Population 41,487)
LEGEND
Regional Health Authority
Rural Municipalities
Roads
Indian Reserves
Hospital
Hospital with attached Special Care Home
Health Centre
Health Centre with attached Special Care Home
Special Care Home
Cumberland House
Smeaton
Choiceland
Love
White Fox
Tobin Lake
Nipawin
Codette
Carrot River
Aylsham
Arborfield
Ridgedale
Zenon Park
MELFORT
Star City
Tisdale
Mistatim
Hudson Bay
Yellow Creek
St. Brieux
Bjorkdale
Porcupine Plain
Chelan
Weekes
Archerwill
Naicam
Rose Valley
Kelvington
Lintlaw
HISC: GIS Unit, RA, 01/16/2008, RHA_08.DWG

Kelsey Trail Health Region

Regional Office
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